Thank you for choosing The Hanover for your Workers' Compensation needs. We are pleased to provide you with some information regarding future filing of claims, and other state specific information that will assist you with your claims reporting. You will find this information in the enclosed packet.

The Hanover has four methods for reporting new workers' compensation losses:

Phone In:	Call 1-800-628-0250, follow prompts for reporting WC new losses.
Fax In:	Fax completed First Report to 1-800-762-7788
Online:	www.hanover.com Choose "Report a Claim" at the top of the page, then choose "Workers' Compensation Claim" under Business Claims.
E-Mail:	E-mail completed First Report of Injury to WCNEWLOSSES@hanover.com

All four options are available 24 hours per day, 7 days per week. Upon receipt and entry of your claim into our system, your agent will receive a notification of the claim for their records. This occurs within 1 business day of receipt of your report.

The most essential part of a workers' compensation claim is prompt notification to us to allow prompt investigation, payment of benefits to your injured worker if appropriate, and to avoid any potential for late filing penalties that may be assessed by your state.

Welcome to The Hanover.

We look forward to working with you.

DISABILITY COMPENSATION LAW

NOTICE TO EMPLOYEES

Workers' Compensation - You have the right to receive workers' compensation benefits and medical care if you suffer a work-related injury. You must report the date, time and circumstance of your injury immediately to your employer or supervisor. Give the name of the insurer to your doctor so that your doctor will know where to send the physician's report. If your employer does not file a report of the injury, you may file a written claim with the Disability Compensation Division. You do not pay for the premium cost; your employer pays the entire amount.

You are entitled to all required medical, surgical and hospital services and supplies including medication; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the Department; additional benefits if the injury results in permanent disability or disfigurement; vocational rehabilitation, if appropriate; funeral and burial expenses if the work injury results in death; and additional weekly benefits to the surviving spouse and other dependents.

Temporary Disability Insurance - You have the right to file a claim for temporary disability insurance benefits within 90 days from the date of disability if you suffer a disabling nonwork-related injury/illness, or inability to work because of your pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form. You may receive TDI benefits if your inability to work is properly certified by a physician. Generally, you must have worked for an employer in Hawaii at least two weeks prior to your disability. During the last 52 weeks, you must have: worked for at least 14 weeks; been paid for at least 20 hours per week; and earned at least $400.

After a 7 consecutive day waiting period, you will be paid 58% of your average weekly wage, not to exceed the maximum in the TDI law. Your employer may have an "equivalent" plan approved by the Department, which may provide different benefits. You should ask your employer for details if they have an "equivalent" plan.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost and should not exceed .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are not eligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

Prepaid Health Care - You have the right to enroll in your employer's prepaid health care insurance plan after 4 consecutive weeks of employment where you have worked at least 20 hours each week. The health care plan must be approved by the Department and include insurance coverage for hospital, surgical, medical, diagnostic and maternity medical care.
You should claim benefits under this program if a nonwork-related injury or illness requires medical care. Give your doctor or hospital the name of your employer's health care contractor and the plan name.

If you are required to share in the premium cost for your coverage, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

Disability Compensation Division:

Oahu: . . . . . 586-9161 (Workers' Compensation)
586-9188 (Temporary Disability Insurance and Prepaid Health Care)
Hilo: 974-6464
Kona: 322-4808
Maui: 243-5322
Kauai: 274-3351

This notice provides general background information on labor laws administered and enforced by DLIR's Disability Compensation Division and is not intended to serve as a substitute for legal counsel. For specific legal advice on individual situations, please consult an attorney.

Nelson B. Befitel, Director
Department of Labor and Industrial Relations

*You may satisfy Hawaii Labor Laws' posting requirements by posting our official labor law poster.
Click this link for more information: http://hawaii.gov/labor/poster_2006.shtml

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 38695, LC.) IF U.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

CASE NUMBER

NOTE: DO NOT WRITE IN SHADED BLOCKS

IDENTIFICATION SECTION

EMPLOYEE NAME - LAST | FIRST | M.I. | SOC. SEC. NO. | DATE OF BIRTH MM / DD / YY | SEX ☐ MALE ☐ FEMALE | MARITAL STATUS MARRIED ☐ SINGLE ☐ | DATE RECEIVED MM / DD / YY

ADDRESS | ADDITIONAL ADDRESS INFORMATION (C/O) | CITY | STATE | ZIP CODE

PAY RATE | OCCUPATION | DATE HIRED MM / DD / YY | YRS EMP'D CODE | DEPARTMENT | PAYROLL COMP CLASS CODE | OCC. CODE

REGISTERED EMPLOYER | DBA

ADDRESS | CITY | STATE | ZIP CODE

FEIN# | NATURE OF BUSINESS | DATE INJURY/ILLNESS REPORTED MM / DD / YY | DATE OF INJURY/ILLNESS MM / DD / YY | PREFAB ☐ WC-2 ☐ WC-5 | DOL NUMBER | DBA

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS ____ AM ____ PM | TIME OF DI CODE | PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS | CITY | STATE | ON EMPLOYER'S PREMISES ☐ YES ☐ NO | INDUSTRIAL CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)

TIME WORKSHIFT BEGAN ____ AM ____ PM

SOURCE OF INJURY | EVENT

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)

TASK | ACTIVITY | ACCIDENT FACTOR

AOE

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY/ILLNESS AND PART OF THE BODY AFFECTED

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT	☐	☐		
BURNS	☐	☐		

TIME LOST INFORMATION

DATE DISABILITY BEGAN MM / DD / YY | WAS EMPLOYEE FURNISHED MEALS OR LODGING ☐ YES ☐ NO | AVG WKLY WAGE | IF EMPLOYEE IS BACK TO WORK GIVE DATE MM / DD / YY | WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS ☐ YES ☐ NO | IF EMPLOYEE DIED GIVE DATE MM / DD / YY | HOURLY WAGE | MONTHLY SALARY | HRS WORKED / WK | WEIGHING FACTOR

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN | ADDRESS | PHYSICIANS I.D. CODE

NAME OF MEDICAL FACILITY | ADDRESS | INPATIENT OVERNIGHT? ☐ YES ☐ NO | EMERGENCY ROOM ONLY? ☐ YES ☐ NO

CARRIER I.D.

INSURANCE

NAME OF WC INSURANCE CARRIER | NAME OF ADJUSTING COMPANY | IF LIABILITY DENIED – WHY? | IS LIABILITY DENIED? ☐ YES ☐ NO

POLICY NO. | POLICY PERIOD | ADJUSTER NAME | CARRIER CASE NO.

ADJUSTER I.D. | MEDICAL DENIED Y/N

SIGNATURE

TITLE | DATE MM / DD / YY

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
NOTICE TO EMPLOYEES

YOUR EMPLOYER IS REQUIRED TO PROVIDE YOU WITH WORKERS' COMPENSATION (WC), TEMPORARY DISABILITY INSURANCE (TDI), AND PREPAID HEALTH CARE (PHC) COVERAGE. TO UNDERSTAND YOUR BENEFIT RIGHTS UNDER THESE PROGRAMS, READ THIS NOTICE CAREFULLY. CONTACT THE DISABILITY COMPENSATION DIVISION OFFICE LISTED BELOW FOR FURTHER INFORMATION.

WORKERS' COMPENSATION

You should claim benefits under this program if you suffer a work-connected injury. Report the date, time and circumstances of your injury immediately to your employer or supervisor. Give name of insurer to your doctor so that he will know where to send the report of industrial injury. If your employer does not file a report of injury, you may file a written claim with the workers' compensation office.

You are entitled to free choice of physician; all required medical, surgical and hospital services and supplies including drugs; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the workers' compensation office; additional benefits if injury results in permanent disability or disfigurement; vocational rehabilitation; funeral and burial expenses if work injury results in death; additional weekly benefits to surviving spouse and other dependents; and concurrent temporary total disability benefits if employed with two covered employers at time of injury.

If your workers' compensation benefits are disputed and you are not paid, you may file a temporary disability insurance claim with your employer's temporary disability insurance carrier. The temporary disability insurance carrier will pay you temporary disability insurance benefits if you are eligible, but the carrier will have lien rights to your workers' compensation benefits.

You do not pay for premium cost; your employer pays entire amount.

TEMPORARY DISABILITY INSURANCE

You should claim under this program within 90 days from disability date if you suffer a disabling nonwork-related injury, illness or pregnancy. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form.

To be eligible, your disability must be properly certified and you must have been performing regular service in employment not longer than 2 weeks prior to the onset of your disability. You must have been in covered employment with any Hawaii employer for at least 14 weeks with remuneration of 20 or more hours in each week and earned wages of at least $400 during the 52 weeks immediately preceding the first day of your disability.

After a 7-consecutive-day waiting period, you are entitled to 58% of your average weekly wage not exceeding the maximum weekly benefit amount set annually by the Temporary Disability Insurance office, for a maximum of 26 weeks during a benefit year if your employer has a statutory plan. If your employer has an approved other-than-statutory plan, ask your employer for details on benefit amount, waiting period and benefit duration.

You may be required by your employer to share in the premium cost. Your share cannot be more than one-half of the cost nor more than .5% of your weekly wages. Your employer pays the remaining portion exceeding the prescribed limitation. If you are ineligible for benefits (see second paragraph above), your employer cannot deduct any contributions from you to share in the premium cost.

PREPAID HEALTH CARE

You should claim benefits under this program if a nonwork-connected injury or illness requires medical care. Give to your doctor or hospital the name of your employer's health care contractor and the plan ID number listed below.

After 4 consecutive weeks of employment of a least 20 hours each week, you may be entitled to enrollment in your employer's health care plan which should provide: hospital, surgical, medical, diagnostic and maternity benefits.

If you are required to share in the premium cost, your share cannot be more than 1.5% of your monthly wages or one-half the premium cost (whichever is less). Your employer pays the balance.

APPEAL RIGHTS

If you disagree with any decision rendered on your claim for benefits under the workers' compensation, temporary disability insurance or health care programs, you may file an appeal with the Disability Compensation Division.

EMPLOYER CERTIFICATION

In compliance with the Hawaii State Workers' Compensation, Temporary Disability Insurance and Prepaid Health Care Laws, the undersigned certifies that he has provided the following coverage for his employees (check blocks):

WORKERS' COMPENSATION

☒ **Insured plan** Hanover Insurance
(Name of Insurance Carrier)

☐ **Self-Insured plan**
Effective date of coverage _____

TEMPORARY DISABILITY INSURANCE

☐ **Insured plan** _____
(Name of Insurance Carrier)

☐ **Self-Insured plan**
***Class of employees covered** _____

Effective date of coverage _____

PREPAID HEALTH CARE

☐ **HC Contractor plan** _____
(Name of Health Care Contractor)

☐ **Approved self-insured plan** _____
(Name of Plan Administrator)

Plan name _____ ***Classes of employees covered** _____ **Effective Date** _____

*** If more than one plan, indicate whether coverage is for salaried, hourly, bargaining unit, non-bargaining unit, etc. employees.**

EMPLOYER NAME	AUTHORIZED SIGNATURE	TITLE	DATE
Trends International LLC	Carol Kilgore, CPP	Sr HR-PR Manager	7-1-14

317-388-4007

DISABILITY COMPENSATION OFFICES

Oahu:
P.O. Box 3769
830 Punchbowl Street, Room 209
Honolulu, Hawaii 96812-3769
Phone: (808) 86-9188 (TDI/PHC)
(808)586-9161 (WC)

Hawaii:
State Office Building
75 Aupuni Street, #108
Hilo, Hawaii 96720
Phone (808) 974-6464

West Hawaii:
P.O. Box 49
Kealakekua, Hawaii 96750
Phone: (808) 322-4808

Maui:
State Office Building
2264 Aupuni Street, #2
Wailuku, Hawaii 96793
Phone: (808) 243-5322

Kauai
State Office Building
3060 Eiwa Street, #202
Lihue, Hawaii 96766
Phone: (808) 274-3351

THIS FORM MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OF BUSINESS

State Form DC-50 Rev. 8/02 Reproduced by LISH as a member service 9/03.
www.viphawaii.com/lish

221-8686 (5/11)

Form DC-50
Rev. 6/97

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
NOTICE TO EMPLOYEES

YOUR EMPLOYER IS REQUIRED TO PROVIDE YOU WITH WORKERS' COMPENSATION (WC), TEMPORARY DISABILITY INSURANCE (TDI), AND PREPAID HEALTH CARE (PHC) COVERAGE. TO UNDERSTAND YOUR BENEFIT RIGHTS UNDER THESE PROGRAMS, READ THIS NOTICE CAREFULLY. CONTACT THE DISABILITY COMPENSATION DIVISION OFFICES LISTED BELOW FOR FURTHER INFORMATION.

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You are entitled to free choice of physician; all required medical, surgical and hospital services and supplies including drugs; weekly benefits from the fourth day of disability to replace wage loss, representing 66 2/3% of your average weekly wage but not more than the maximum weekly benefit amount annually set by the workers' compensation office; additional benefits if injury results in permanent disability or disfigurement; funeral and burial expenses if work injury results in death; additional weekly benefits to surviving spouse and other dependents; and concurrent temporary total disability benefits if employed with two covered employers at time of injury.

If your workers' compensation benefits are disputed and you are not paid, you may file a temporary disability insurance claim with your employer's temporary disability insurance carrier. The temporary disability insurance carrier will pay you temporary disability insurance benefits if you are eligible, but the carrier will have lien rights to your workers' compensation benefits.

You do not pay for premium cost; your employer pays entire amount.

TEMPORARY DISABILITY INSURANCE

You should claim under this program if you suffer a disabling nonwork-connected injury, illness or pregnancy, within 90 days from disability date. Your employer or insurance carrier should furnish you with a TDI-45 claim form or some other authorized claim form.

To be eligible, your disability must be properly certified and you must have been performing regular service in employment not longer than 2 weeks prior to the onset of your disability. You must have been in covered employment with any Hawaii employer for at least 14 weeks with remuneration of 20 or more hours in each week and earned wages of at least $400 during the four completed calendar quarters immediately preceding the first day of your disability.

After a 7-consecutive-day waiting period, you are entitled to 58% of your average weekly wage for 26 weeks during a benefit year if your employer has a statutory plan. If your employer has an approved other-than-statutory plan, ask for details on benefit amount, waiting period and benefit duration.

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You should claim benefits under this program if a nonwork-connected injury or illness requires medical care. Give to your doctor or hospital the name of your employer's health care contractor and the plan ID number listed below.

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APPEAL RIGHTS

If you disagree with any decision rendered on your claim for benefits under the workers' compensation, temporary disability insurance or health care programs, you may file an appeal with the Disability Compensation Division.

EMPLOYER CERTIFICATION

In compliance with the Hawaii State Workers' Compensation, Temporary Disability Insurance and Prepaid Health Care Laws, the undersigned certifies that he has provided the following coverage for his employees (check blocks):

WORKERS' COMPENSATION

☐ Insured plan HANOVER INSURANCE COMPANY OF AMERIC
(Name of Insurance Carrier)

☐ Self-Insured plan _____

Effective date of coverage 05/01/2014-05/01/2015

TEMPORARY DISABILITY INSURANCE

☐ Insured plan _____
(Name of Insurance Carrier)

☐ Approved self-insured plan

*Classes of employees covered _____

Effective date of coverage _____

PREPAID HEALTH CARE

☐ HC Contractor plan _____
(Name of Health Care Contractor)

☐ Approved private plan _____
(Name of Health Care Contractor)

Plan ID No. WM2-9927384-01 *Classes of employees covered _____ Effective date _____

*If more than one plan, indicate whether coverage is for salaried, hourly, bargaining unit, non-bargaining unit, etc. employees.

EMPLOYER NAME	AUTHORIZED SIGNATURE	TITLE	DATE

DISABILITY COMPENSATION OFFICES

Oahu:
PO Box 3769
830 Punchbowl Street, Room 209
Honolulu, Hawaii 96812-3769
Phone: 586-9188 (TDI)
586-9161 (WC)
586-9191 (PHC)

Hawaii:
State Office Building
75 Aupuni Street, #108
Hilo, Hawaii 96720
Phone: 974-6464

West Hawaii:
Ashikawa Building
P.O. Box 49
Kealakekua, Hawaii 96750
Phone: 322-2775

Maui:
State Office Building
2264 Aupuni Street, #2
Wailuku, Hawaii 96793
Phone: 984-2097

Kauai:
State Office Building
3060 Eiwa Street, #202
Lihue, Hawaii 96766
Phone: 274-3351

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OF BUSINESS

WC 9648 (6/97) INFORMATION SERVICES, INC.