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.

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)

Social Security Number

Date of Accident (Month-Day-Year)

Time of Accident ☐ AM ☐ PM

HOME ADDRESS

Street/Apt #: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH

_____ / _____ / _____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

DATE EMPLOYED

_____ / _____ / _____

PAID FOR DATE OF INJURY ☐ YES ☐ NO

EMPLOYER'S LOCATION ADDRESS (If different)

Street: _____

City: _____ State: _____ Zip: _____

LOCATION # (If applicable) _____

LAST DATE EMPLOYEE WORKED

_____ / _____ / _____

RETURNED TO WORK ☐ YES ☐ NO
IF YES, GIVE DATE

_____ / _____ / _____

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP

_____ / _____ / _____

PLACE OF ACCIDENT (Street, City, State, Zip)

Street: _____

City: _____ State: _____ Zip: _____

COUNTY OF ACCIDENT _____

DATE OF DEATH (If applicable)

_____ / _____ / _____

AGREE WITH DESCRIPTION OF ACCIDENT?

☐ YES ☐ NO

RATE OF PAY ☐ HR ☐ WK

$ _____ PER ☐ DAY ☐ MO

Number of hours per day _____

Number of hours per week _____

Number of days per week _____

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I have reviewed, understand and acknowledge the above statement.

_____ _____
EMPLOYEE SIGNATURE (If available to sign) DATE

_____ _____
EMPLOYER SIGNATURE DATE

NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL

AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached

☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached

☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3)

Employee's 8TH Day of Disability _____ / _____ / _____

Entity's Knowledge of 8TH Day of Disability _____ / _____ / _____

☐ 3. Lost Time Case - 1st day of disability _____ / _____ / _____ Full Salary in lieu of comp? ☐ YES Full Salary End Date _____ / _____ / _____

Date First Payment Mailed _____ / _____ / _____ AWW _____ Comp Rate _____

☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $_____ Interest Amount Paid in 1st Payment $_____

REMARKS:

INSURER NAME

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

INSURER CODE #

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #

CLAIMS-HANDLING ENTITY FILE #

Form DFS-F2-DWC-1 (08/2004)

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

$25,000

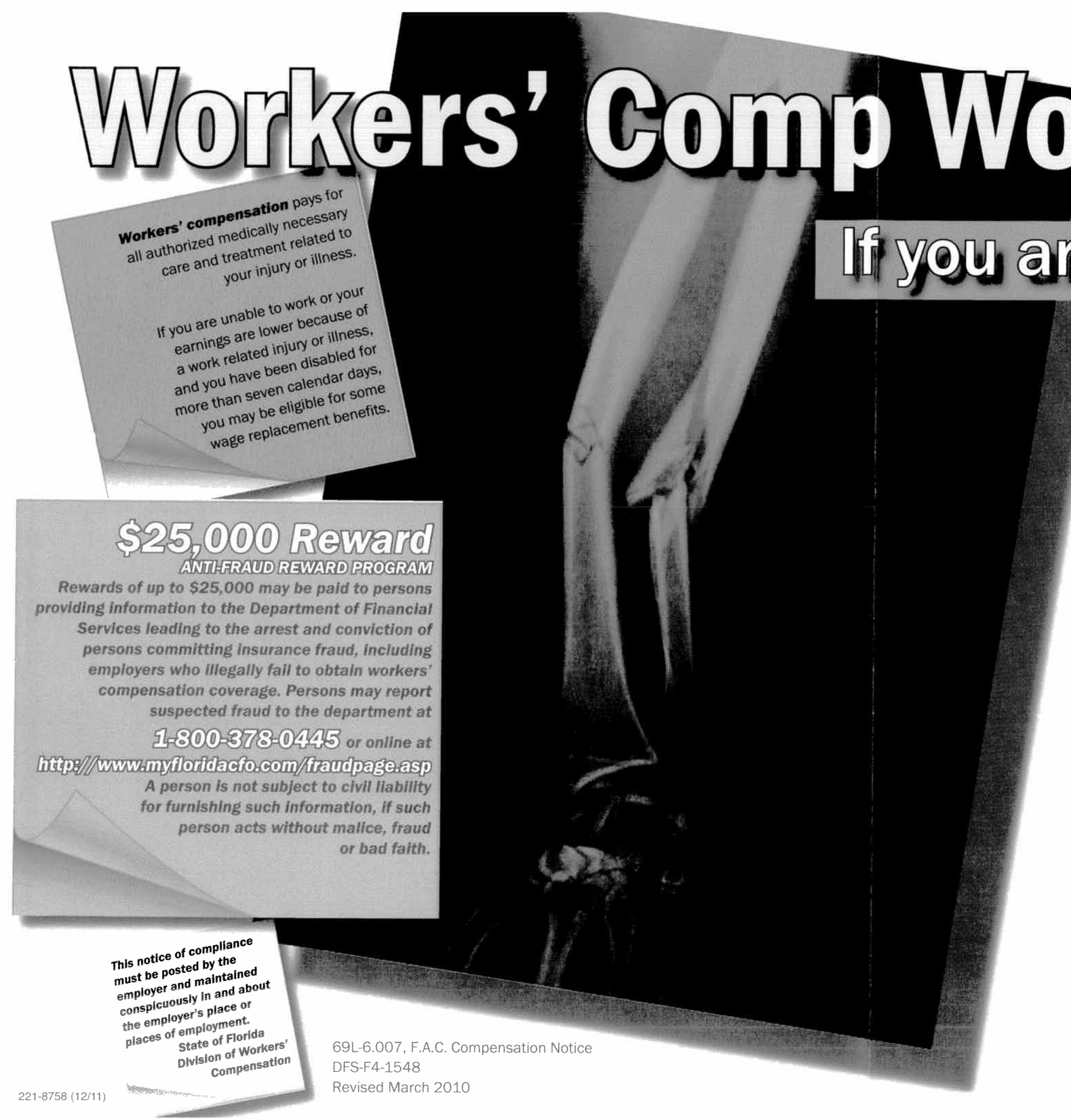
Anti-Fraud Reward Program

Rewards of up to $25,000 may be paid to persons providing information to the Dept of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the Department at 1-800-378-0445.

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

221-8760 (12/11)

Workers' Comp Works For You



Workers' compensation pays for all authorized medically necessary care and treatment related to your injury or illness.

If you are unable to work or your earnings are lower because of a work related injury or illness, and you have been disabled for more than seven calendar days, you may be eligible for some wage replacement benefits.

$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to $25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at **1-800-378-0445** *or online at* **http://www.myfloridacfo.com/fraudpage.asp**

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

This notice of compliance must be posted by the employer and maintained conspicuously in and about the employer's place or places of employment.

State of Florida
Division of Workers' Compensation

69L-6.007, F.A.C. Compensation Notice
DFS-F4-1548
Revised March 2010

221-8758 (12/11)

If you are injured on the job:

1. Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.

2. Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.

3. If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.

The Hanover Insurance Company
440 Lincoln Street P.O. Box 15063
Worcester, MA 01615
(508) 855-1000

HERE

Compensación por accidentes de trabajo labora para usted:

Compensación por accidentes de trabajo paga por todos los gastos médicos y tratamientos autorizados que se relacionen con su lesión u enfermedad y sean médicamente necesarios.

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su trabajo, y ha estado incapacitado por más de siete días, puede que sea elegible para recibir compensación por una porción de su sueldo.

Si usted se lastima en su lugar de empleo:

1. Notifique a su empleador inmediatamente para obtener el nombre de un medico autorizado. Puede que el seguro de compensación por accidentes de trabajo no pague sus cuentas médicas si usted no reporta su accidente lo mas antes posible a su empleador.

2. Notifique al medico y a su personal que usted se lastimó en su lugar de empleo para que las cuentas medicas sean debidamente remitidas.

3. Si usted tiene algún problema con su reclamo o si tiene demasiadas demoras en su tratamiento, comuníquese con la División de Compensación por Accidentes de Trabajo al 1-800-342-1741

Recompensa de $25,000.00

PROGRAMA DE RECOMPENSACIÓN ANTI FRAUDE

*Recompensas de hasta **$25,000.00** pueden ser pagadas a personas que proveen información al Departamento de Servicios Financieros que conduzca al arresto y convicción de aquellos que cometen fraude de seguros, incluyendo empleadores que ilegalmente dejan de obtener un seguro por accidentes de trabajo. Se puede reportar sospechas de fraude al Departamento llamando al **1-800- 378-0445** o por correo electrónico al **http://www.myfloridacfo.com/fraudpage.asp.** Nadie es sujeto a responsabilidad civil por someter dicha información si se actúa sin malicia, fraude o mala fe.*

Esta notificación debe ser colocada y mantenida a la vista por el empleador en y alrededor del lugar o lugares de empleo. Estado de la Florida, División de Compensación por Accidentes de Trabajo

The Hanover Insurance Company
440 Lincoln Street P.O. Box 15063
Worcester, MA 01615
(508) 855-1000

69L-6.007, F.A.C. Compensation Notice
DFS-F4-2026
Revised March 2010

221-8759 (12/11)