



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](http://www.hanover.com) Choose "Report a Claim" at the top of the page, then choose "Workers' Compensation Claim" under Business Claims.

E-Mail:  
[WCNEWLOSSES@hanover.com](mailto: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.

CO

Welcome to The Hanover.  
We look forward to working with you.

**WARNING**

**IF YOU ARE INJURED ON THE  
JOB, WRITTEN NOTICE OF YOUR  
INJURY MUST BE GIVEN TO YOUR  
EMPLOYER WITHIN FOUR  
WORKING DAYS AFTER THE  
ACCIDENT, PURSUANT TO  
SECTION 8-43-102(1) AND (1.5),  
COLORADO REVISED STATUTES.  
IF THE INJURY RESULTS FROM  
YOUR USE OF ALCOHOL OR  
CONTROLLED SUBSTANCES,  
**YOUR WORKERS'  
COMPENSATION DISABILITY  
BENEFITS MAY BE REDUCED BY  
ONE-HALF IN ACCORDANCE WITH  
SECTION 8-42-112.5, COLORADO  
REVISED STATUTES.****

# **AVISO**

**SI SE LASTIMA EN EL TRABAJO,  
DEBE DARLE UN AVISO POR ESCRITO  
A SU EMPLEADOR DENTRO DE  
CUATRO DÍAS LABORABLES DEL  
ACCIDENTE, SEGÚN A LA SECCIÓN  
DE LOS ESTATUOS REVISADOS DE  
COLORADO 8-43-102(1) Y (1.5).**

**SI EL ACCIDENTE RESULTA DEBIDO  
AL USO DE ALCOHOL O UNA  
SUSTANCIA CONTROLADA, SUS  
BENEFICIOS DE LA INCAPACIDAD  
DE LA COMPENSACIÓN DE LOS  
TRABAJADORES PUEDEN SER  
REDUCIDOS POR UN MEDIO EN  
ACUERDO DE LA SECCIÓN DE LOS  
ESTATUOS REVISADOS DE  
COLORADO 8-42-112.5.**

## COLORADO WORKERS' COMPENSATION INFORMATION

Your employer has workers' compensation coverage for employees through:

Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly, your benefits may be reduced.

If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.

You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.

You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303.318.8700, or visit our website at: [www.coworkforce.com/dwc/](http://www.coworkforce.com/dwc/).

**COLORADO DIVISION OF WORKERS' COMPENSATION**  
633 17<sup>th</sup> Street, Suite 400, Denver, CO 80202-3626

Any information provided below comes from your employer and is specific to this place of employment:

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION



**EMPLOYER'S FIRST REPORT OF INJURY**

Employee's name (first, middle, last)		Social Security #		<input type="checkbox"/> Male	Employee's home phone #		OSHA		
Employee's street address				<input type="checkbox"/> Female					
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown	Date of hire / /	City	State	Zip code	Log #			
Employer's name		Employer's Federal ID #		Occupation		Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown	For Division use only SOI		
Employer's mailing address				City		Employer's phone # ( )	POB		
Average weekly wage at time of injury \$ (see instructions on reverse side)		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			NOI		
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124?¹ <input type="checkbox"/> Yes <input type="checkbox"/> No			Coder		
Injury/Illness date / / (See instructions on reverse side)	Time employee began work ____ <input type="checkbox"/> a.m. ____ <input type="checkbox"/> p.m.	Injury time ____ <input type="checkbox"/> a.m. ____ <input type="checkbox"/> p.m. <input type="checkbox"/> unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /			
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death					Injury occurred because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Safety violation <input type="checkbox"/> Not applicable		
Tell us the part of body that was affected			Tell us the nature of the injury/illness²						
What was the employee doing just before the accident occurred?³									
Tell us how the injury occurred⁴			What object or substance directly harmed the employee?⁵						
Did injury occur on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code		Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital			Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Names of witnesses			Name of employer representative notified						
Name and address of treating doctor or other health care professional			Name and address of facility where treated						
Completed by (name)		Title		Phone # ( )		Date completed / /			
<b>The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.</b>									
Name of insurance company			Address						
Name of third party administrator (if applicable)			Address						
Adjuster name			Adjuster phone #						
Policy #	Carrier claim #		Date insurer received first report / /			Block #	Adj. Code		

## INSTRUCTIONS

**This form contains all items requested on OSHA Form No. 301,  
"Injuries & Illnesses Incident Report"**

### **General**

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

### **Calculation of Average Weekly Wage**

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability*.
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

### **Injury Date Information**

In the case of an occupational disease, use the date of the last injurious exposure.

### **Notes**

Are Wages continued per C.R.S. 8-42-124?<sup>1</sup>

(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

- 1 Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness<sup>2</sup>; What was the employee doing just before the accident occurred?<sup>3</sup>; What happened?<sup>4</sup>; What object or substance directly harmed the employee?<sup>5</sup>)

- 2 Be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 3 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
- 4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

### **Notices**

**You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.**

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

# C O R V E L

Trends International, Llc - Colorado Panel Physician  
Listing

CO

**Please Remember**

If you are injured on the job, please contact your supervisor immediately.

Get medical attention from one of the providers listed.

You may reach CorVel for assistance in locating a physician within our network by dialing 888-699-6665 or e-mail us at [inquiry@corvel.com](mailto:inquiry@corvel.com).

# **C O R V E L**

Trends International, LLC - Colorado Panel Physician  
Listing

CO

**If the injury is a medical emergency, ensure that the injured employee  
is transported to the nearest emergency treatment facility.**

**If you need assistance making an appointment for medical treatment,  
you may call CorVel toll-free at 888-699-6665.**

**You may reach CorVel for assistance in locating a physician within our  
network by dialing 888-699-6665 or e-mail us at [inquiry@corvel.com](mailto:inquiry@corvel.com)**

**For Assistance in Scheduling MRI or Diagnostic Testing Call 888-922-7347**

**CorVel has made every effort to ensure the accuracy of this listing. However, changes may occur daily. We recommend that you confirm with the healthcare provider, prior to receiving services, that he/she is currently participating with CorVel or one of CorVel's affiliate networks.tworks.**