The Hanover Insurance Group®

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.

VERMONT

DEPARTMENT OF LABOR · ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488

Form 1 (Rev. 2/09)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Complete form and send original to the Commissioner of Labor within 72 hours of accident. Send duplicate to your workers' compensation insurance company, give Employee's copy to employee and retain Employer's copy for your files. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name:
2. Business Name:
3. Mail Address: No. and Street | City | State | Zip
4. Location (if different from Mail Address):
5. Federal ID No.:
6. Nature of Business (list principal products or service of concern):
7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No
8. Telephone No.:

EMPLOYEE

9. Name: First Name | Middle Initial | Last Name
10. Social Security No.:
11. Date of Birth:
12. Home Address: No. and Street
13. Telephone No.:
14. Job Title:
15. Age:
City | State | Zip
16. Dept. assigned to:
17. Sex: ☐ M ☐ F
18. Wages $ Per | Hours Per Day Days Per Week
19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $
20. Was employee hired in VT? ☐ Yes ☐ No
21. Date of Hire

ACCIDENT

22. Date of Accident:
Accident Time: AM PM
Began Shift: AM PM
23. Location of Accident: Town or City | State
24. Machine or tool involved in the accident:
25. Was it defective? ☐ Yes ☐ No
26. On employer's premises? ☐ Yes ☐ No
If yes, name of department:
27. Object or substance directly causing injury:
28. Describe what employee was doing:
Was this the employee's regular occupation? ☐ Yes ☐ No
29. How did accident occur? Describe events leading up to the accident:
30. Can the employer prevent this type of accident? ☐ Yes ☐ No
If yes, describe how.
31. Was safety equipment, such as goggles or guards, etc. provided? ☐ Yes ☐ No
32. Could the injured have prevented this type of accident? ☐ Yes ☐ No
If yes, describe how (do not say "By being more careful".
33. If safety equipment was provided, was it being used? ☐ Yes ☐ No

INJURY

34. Describe the injury and the part of the body injured.
35. Was this a first-aid only injury: ☐ Yes ☐ No
36. Any Lost Time? ☐ Yes ☐ No
If yes, date disability began
Last date paid in full:
37. Employee returned to work? ☐ Yes ☐ No
If yes, date
At what weekly wage:
38. Did injury result in death? ☐ Yes ☐ No
If yes, date of death.
39. If death, name and address of nearest relative.
Relationship
40. Name and address of Physician
41. Name and address of Hospital:
Remained Overnight ☐ Yes ☐ No

INS

42. Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.
Name in full:
Policy No.
Signed by:
Employer or Representative | Title | Date

Provided Form 8 Dept. of Labor Ins. Co. Employer Employee

Equal Opportunity is the Law

VERMONT
DEPARTMENT OF LABOR

Employer's Reinstatement Liability

This notice is informational and required under the law.

Employer and employee are hereby advised of the existence and significant provisions of 21 VSA §643B.

This law provides that an employer who regularly employees **ten or more** people, may have an obligation to rehire a worker who has suffered a work related injury **provided** that the following conditions are met:

1. The worker recovers from the injury within two (2) years; and

2. The worker keeps the employer informed of his or her interest in reinstatement and his or her current address; and

3. The worker had an expectation of continuing work had the injury not occurred; and

4. The worker is physically capable or performing either his or her prior job, if available, or an alternative suitable position.

Reinstatement must be with all benefits eared up to the date of injury, including both seniority and accrued leave time. Obviously, such benefits need not accrue **during** the period of actual disability.

Please note that the right to reinstatement applies only to the first **available** suitable job. Thus, the employer is not obligated either to create an "extra" position for a returning worker or to lay-off a current employee in order to comply with this law.

Should you have questions regarding the above, please contact the Vermont Department of Labor, Workers' Compensation Division at 802-828-2286 or our website: www.labor.vermont.gov.

VERMONT

DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, TRENDS INTERNATIONAL LLC **, has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:**

THE HANOVER INSURANCE COMPANY

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**