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.

The Hanover Insurance Group®

The Hanover Insurance Company | 440 Lincoln Street, Worcester, MA 01653
Citizens Insurance Company of America | 645 West Grand River Avenue, Howell, MI 48843

Employer's Notice of Insurance

Insurer: Trends International LLC

Street and Number: 5188 W 74th St

City: Indianapolis State: IN Zip Code: 46268

For the period from: 5-15-14 Through: 5-15-15

Adjusting Company: Hanover Insurance

Street and Number: 440 Lincoln St,

City: Worcester State: MA Zip Code: 01615 Telephone: 508-855-1000

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act.

Employer: Trends International LLC

By: Carol Kilgore, CPP

Title: Sr HR-PR Manager

Witness: Lisa Alexander

Witness: Kelli Reney

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose.

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Suite 304
Anchorage AK 99503
(907) 269-4980

FAIRBANKS
675 Seventh Avenue
Station K
Fairbanks AK 99701-4586
(907) 451-2889

JUNEAU
PO Box 115512
1111 W 8th St Room 305
Juneau AK 99811-5512
(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

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Report of Occupational Injury or Illness

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
P.O. Box 115512, Juneau AK 99811-5512

AWCB Case Number (Division Use Only):

EMPLOYEE: Answer ALL questions 1-20, sign, and give to your employer immediately.

1. Last Name	First Name	Initial	2. Telephone Number	3. Date of Birth	4. Sex	5. Social Security No.

6. Mailing Address	7. Residence Address
6a. City / State / Zip Code	7a. City / State / Zip Code

8. Place (City/Town/Village/Camp) Where Injury/Occupational Illness Happened	9. Date of Injury or Exposure to Disease	10. On Employer's Premises?

11. Name and Address of Attending Physician	12. Hospitalization In-Patient?	13. Name of Hospital
City / State / Zip Code	City / State / Zip Code	

14. Describe Part(s) of Body Injured/Nature of Occupational Illness ☐ Left ☐ Right	15. Describe how the Injury or Occupational Illness happened

16. To all health care providers:
You are authorized to provide my employer (named in box 18), its workers' compensation liability insurance company (box 21), and its claims adjuster (box 22) information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 14. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature (box 17a). I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

Employee/Patient's Signature:

17. If Employee Unavailable for Signature, Explain Circumstances in this Space	17a. Date Signed

EMPLOYER: Review employee answers 18-20, answer questions 21-49

18. Employer's Name	19. Employer's Alaska Address (If Different from Mailing)
20. Employer's Mailing Address (Street and Number)	21. Name of Insurer
20a. City / State / Zip Code / 20b. Telephone	22. Full Name and Address of Adjusting Company

23. Date Employer First Knew of Injury	24. Date/Time (AM/PM) Employee Left Work	22a. Mailing Address (Street and Number)

25. Off Work After Injury/Illness? ☐ Yes ☐ No	26. Date Returned to Work	27. Death? ☐ Yes ☐ No Date	22b. City / State / Zip Code	22c. Telephone

28. Location Where Injury or Occupational Illness Happened	29. Employee's Occupation	30. Date Hired by Employer

31. Earnings Calculated By ☐ Hr. ☐ Day ☐ Output ☐ Wk. ☐ Mo. ☐ Yr.	32. Rate of Pay $ per	33. Days Employee Works per Week ☐ 3 or Less ☐ 4 ☐ 5 ☐ 6 ☐ 7	34. Describe Scheduled Days Off

35. Workday Began ☐ AM ☐ PM	36. Employee Paid for Day Injured or Ill? ☐ Yes ☐ No	37. Federal EIN #	38. Give Details of How Injury or Illness Happened

39. Injury/Illness Due to Machine? Product Failure? ☐ Yes ☐ No	40. Mechanical Guard/Safeguards Provided? ☐ Yes ☐ No	41. List Any Machine/Substance/Object Causing Injury	42. If Machine, What Part

43. Name and Address of Witnesses	If Injury/Illness Caused by Anyone Besides Employee, Give Name and Address

46. If You Doubt Validity of Injury or Illness, State Reason

47. Signature of Authorized Employer or Representative	48. Title	49. Date Signed