



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.

Compensación del Trabajador

Si usted se lesiona en el trabajo, usted debe:

1. Notificar a su patrón inmediatamente. Usted no puede recibir beneficios a menos que su patrón sepa que se ha lesionado.
2. Decirle al doctor al que su patrón le envíe que usted está cubierto por la Compensación del Trabajador.
3. Notificar al Proveedor de Compensación del Trabajador abajo mencionado o a la Comisión de Compensación del Trabajador de Carolina del Sur al (803) 737-5700 si usted tiene retrasos o problemas indebidos con su reclamación.

La Compensación del Trabajador:

1. Paga el 100% de sus recibos médicos y otros gastos.
2. Le compensa por el 66 2/3% de su salario, limitado al salario máximo establecido por la ley, si usted no puede trabajar por más de siete (7) días calendario.

Trabajamos conforme al Acto de Compensación del Trabajador de Carolina del Sur

En caso de lesión accidental o muerte de un empleado, el empleado lesionado, o alguien que le represente, tiene que avisar inmediatamente al patrón o agente autorizado general. El hecho de no avisar inmediatamente puede causar una demora seria en el pago de la compensación al empleado lesionado o a sus dependientes y puede resultar en el impago de los beneficios de compensación según estipula la ley.

**S.C. Workers' Compensation Commission
(Comisión de Compensación de Trabajadores)
P.O. Box 1715, 1612 Marion Street
Columbia, SC 29202-1715
(803) 737-5700
www.wcc.state.sc.us**

Workers' Compensation

If you are injured on the job, you should:

1. Notify your employer at once. You can't receive benefits unless your employer knows you're injured.
2. Tell the doctor your employer sends you to that you're covered by Workers' Comp.
3. Notify the Workers' Comp. Provider below or the S.C. Workers' Comp. Commission at (803) 737-5700 if you experience undue delays or problems with your claim.

Workers' Compensation:

1. Pays 100% of your medical bills and some other expenses.
2. Compensates you for 66 2/3% of your salary, limited to the maximum wage set by law, if you are unable to work for more than seven (7) calendar days.

We are operating under and subject to the S.C. Workers' Compensation Act

In case of accidental injury or death to an employee, the injured employee, or someone acting in his or her behalf, must give immediate notice to the employer or general authorized agent. Failure to give such immediate notice may be the cause of serious delay in the payment of compensation to the injured employee or his or her dependents and may result in failure to receive any compensation benefits under the law.

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P.O. Box 1715, 1612 Marion Street
Columbia, S.C. 29202-1715
(803) 737-5700
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S.C. WORKERS' COMPENSATION COMMISSION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #
INDUSTRY CODE	EMPLOYER FEIN			PHONE #

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE #)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	<p>TO</p> <p>CHECK IF APPROPRIATE</p> <p><input type="checkbox"/> SELF INSURANCE</p>	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	MARITAL STATUS <input type="checkbox"/> Unmarried/Single/Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown	OCCUPATION/JOB TITLE	
			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS	NCCI CLASS CODE		
RATE PER:	<input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE (<input type="checkbox"/>) CANNOT BE DETERMINED <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED DATE DISABILITY BEGAN		
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED		WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL		DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT		CAUSE OF INJURY CODE		
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? <input type="checkbox"/> YES <input type="checkbox"/> NO WERE THEY USED? <input type="checkbox"/> YES <input type="checkbox"/> NO				
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				
					INITIAL TREATMENT	
					0 <input type="checkbox"/>	
					1 <input type="checkbox"/>	
					2 <input type="checkbox"/>	
					3 <input type="checkbox"/>	
4 <input type="checkbox"/>		HOSPITALIZED > 24 HOURS				
5 <input type="checkbox"/>		FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED				

OTHER

WITNESSES (NAME & PHONE #)			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE	PHONE NUMBER



South Carolina Workers' Compensation Commission

1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5722

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YYYY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:
Full-Time On Strike Unknown Volunteer
Part-Time Disabled Apprenticeship Full-Time Seasonal
Not Employed Retired Apprenticeship Part-Time Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (e.g. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (e.g. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location.
Be specific.



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EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(e.g. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (e.g. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.