



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.

WORKERS' COMPENSATION

LA COMPENSACIÓN DEL TRABAJADOR

in
en **Maryland**

Job Related Accidental Personal Injury or Occupational Disease?

If you are disabled and unable to work for more than three (3) days, your employer's workers' compensation insurance company may pay your medical bills and other expenses and replace two-thirds (2/3) of your salary (limited to the maximum set by law).

If you are injured on the job:

1. Notify your employer or supervisor at once. You cannot receive full benefits unless your employer knows you are injured.
2. Tell the doctor who treats you that you were hurt on the job.
3. Complete an Employee's Claim Form C-1 (available by phone or on the Commission's website) and send it to us as soon as possible.

Note: Withholding information or giving false information about any work-related activity or return to work could prevent you from receiving benefits and may subject you to fines, imprisonment or both.

Employer/Empleador TRENDS INTERNATIONAL LLC

Business Address/Dirección NO ADDRESS LISTED;

City/State/Zip STATE OF MARYLAND

Ciudad/Estado/Código Postal

Federal Employer ID (FEIN) 260087431

Identificación Federal Del Empleador

Telephone Number/Número Telefónico 311-388-4001

Insurance Company Name THE HANOVER INSURANCE COMPANY

La Compañía de Seguro

Insurance Company Telephone 508-855-1000

Telefónico de la Compañía de Seguro

MD WCC Form C-24 11/2007

221-8796 (1/12)

¿Accidentes por lesión/daño corporal relacionados con el Empleo o Enfermedad Profesional?

Si usted se encuentra incapacitado o inhabilitado para trabajar por más de tres días, el seguro de trabajadores que tienen las compañías pudiera cubrir las facturas médicas y otros gastos relacionados. También le compensarían 2/3 de sus ingresos (Hasta un monto máximo estipulado por la ley).

Si usted sufre una lesión en el trabajo, debe:

1. Informarle a su empleador o supervisor de inmediato. No podría recibir todos sus beneficios a menos que su empleador fuere notificado que sufrió una lesión.
2. Informarle al médico quien le administre tratamiento que usted se lesionó en su trabajo.
3. Llenar el formulario Employee's Claim Form C-1 (disponible consultando la página del Internet para el Workers' Compensation o solicitando uno por teléfono). Diligenciarlo para que las oficinas del Workers' Compensation lo reciban lo antes posible.

Aviso: El suministrar información falsa u ocultar información sobre cualquier actividad relacionada con su trabajo o relacionada con su regreso al trabajo, pudiera afectar los beneficios que recibiera o pudiera acarrearle multas, encarcelamiento o ambas.

Maryland Workers' Compensation Commission

10 East Baltimore Street, Baltimore, Maryland 21202-1641

(410) 864-5100 / Outside Baltimore (800) 492-0479

Webpage - <http://www.wcc.state.md.us> / TTY Users - 711 in Maryland or (800) 735-2258

This notice must be printed on 8.5" X 14" gold or yellow paper, display complete employer information and be posted in a conspicuous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.03.

WORKERS COMPENSATION - 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)					
				TO							
				CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE							
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		MARITAL STATUS		OCCUPATION/JOB TITLE			
				<input type="checkbox"/> M MALE <input type="checkbox"/> F FEMALE <input type="checkbox"/> U UNKNOWN		<input type="checkbox"/> U UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> M MARRIED <input type="checkbox"/> S SEPARATED <input type="checkbox"/> K UNKNOWN		EMPLOYMENT STATUS			
				# OF DEPENDENTS				NCCI CLASS CODE			
PHONE											
RATE PER:		DAY WEEK		MONTH OTHER:		DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY? DID SALARY CONTINUE?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
OCCURRENCE/TREATMENT											
TIME EMPLOYEE BEGAN WORK		AM PM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM PM		LAST WORK DATE	
						() CANNOT BE DETERMINED				DATE EMPLOYER NOTIFIED	
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS				PART OF BODY AFFECTED			
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE				PART OF BODY AFFECTED CODE			
<input type="checkbox"/> YES <input type="checkbox"/> NO											
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. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.										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 <input type="checkbox"/> YES <input type="checkbox"/> NO					
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)				INITIAL TREATMENT			
								0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HOURS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
OTHER											
WITNESSES (NAME & PHONE #)											
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER			

FORM IA-1(r 1-1-02)

SEE BACK FOR IMPORTANT INFORMATION

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EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY 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, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

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

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. 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.

EMPLOYER'S INSTRUCTIONS – cont'd

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

(eg. 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:

(eg. 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 (eg. 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.