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.

State of Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK

Date filed in Chairman's Office

(for WCC use only)

Employer *(Name, Address & Zip)* | Phone # | Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

SIC Code | FEIN

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured | Policy Period *(MM/DD/YY)* FROM TO

Employee Last Name | First Name | Middle Name | Gender ☐ Male ☐ Female

D O B *(required)* | Phone #

Address *(incl Zip)*

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per ☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other | NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)* | Town of Injury / Illness

Time Employee Began Work ☐ a m ☐ p m | Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p m | Type of Injury / Illness

Part of Body Affected

Date Employer Notified *(MM/DD/YY)* | Type of Injury / Illness Code

Date Disability Began *(MM/DD/YY)* | Part of Body Affected Code

Date Last Worked *(MM/DD/YY)* | Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

Date Return(ed) to Work *(MM/DD/YY)* | If provided, were they used? ☐ Yes ☐ No

If Fatal, Date of Death *(MM/DD/YY)* | How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred

Contact Name

Phone #

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment ☐ Emergency Care

☐ Minor — by Employer ☐ Hospitalized More Than 24 Hours

☐ Minor — by Clinic / Hospital ☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

WORKERS' COMPENSATION in Maryland
LA COMPENSACIÓN DEL TRABAJADOR en

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
Ciudad/Estado/Código Postal STATE OF MARYLAND

Federal Employer ID (FEIN) 260087431
Indentificación Federal Del Empleador

Telephone Number/Número Telefónico 317-388-4001

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 solicitándo 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.