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.

FORM 122

For your protection: Utah Law requires notice that worker's compensation fraud is a crime. Please see back of this form for the full fraud statement.

WORKER'S COMPENSATION EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS
STATE OF UTAH - THE LABOR COMMISSION - DIVISION OF INDUSTRIAL ACCIDENTS
160 E 300 S, P.O. BOX 146610
SALT LAKE CITY, UTAH 84114-6610

GENERAL

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 ADMIN

CARRIER/CLAIMS ADMINISTRATOR

CARRIER (NAME, ADDRESS, & PHONE#)	POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS, & PHONE NO)
	CHECK IF APPROPRIATE ☐ SELF INSURANCE	

CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME AND CODE NUMBER		

EMPLOYEE

EMPLOYEE/WAGE

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)	SEX: M MALE, F FEMALE, U UNKNOWN	MARITAL STATUS: U UNMARRIED SINGLE/DIVORCE, M MARRIED, S SEPARATED, K UNKNOWN	OCCUPATION / JOB TITLE	
			EMPLOYMENT STATUS	
PHONE	# OF DEPENDENTS		NCCI CLASS CODE	

WAGE

RATE	PER:	DAY	MONTH	# OF DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	YES	NO
		WEEK	OTHER		DID SALARY CONTINUE?	YES	NO

OCCURRENCE

OCCURRENCE/TREATMENT

TIME EMPLOYEE BEGAN WORK	AM / PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM / 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? ☐ YES ☐ 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 / CAUSE OF INJURY CODE

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

DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? YES / NO	WERE THEY USED? YES / NO

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAMES & ADDRESS)	HOSPITAL (NAME & ADDRESS)	INITIAL TREATMENT
		0 NO MEDICAL TREATMENT 1 MINOR: BY EMPLOYER 2 MINOR CLINIC/HOSP 3 EMERGENCY CARE 4 HOSPITALIZED > 24 HRS 5 FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

OTHER

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

Labor Commission W.C. Insurance Carrier Employee Employer's File

FRAUD - "Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

EMPLOYEE INFORMATION

- **INJURY/ILLNESS REPORT**: A report of your injury/ occupational illness must be made with your employer. If a report of injury is not filed with your employer or the Labor Commission, Division of Industrial Accidents, within 180 days of the date of your injury/illness, you may lose the right to ever file a claim for workers' compensation benefits for that injury or illness.

- **EMPLOYER'S PHYSICIAN:** If your employer has a company physician or designated clinic for industrial accidents, you MUST see the company physician first, or you may not be eligible for workers' compensation benefits. After you have been seen by your employer's physician, you have the right to choose one treating physician.

- **MEDICAL COOPERATION:** You must cooperate with your employer or the insurance carrier in following prescribed medical treatment in order to return to work as quickly as possible.

- **TRAVEL REIMBURSEMENT:** You may be eligible for travel reimbursement to and from approved medical care. You will need to keep records. Contact your insurance carrier regarding travel expenses.

- **REEMPLOYMENT ASSISTANCE:** You may be eligible for reemployment assistance if you are unable to return to work due to an industrial injury. Contact your insurance carrier or the Labor Commission, Division of Industrial Accidents, for further information.

- **MEDICAL EXPENSES:** You are entitled to have all reasonable medical expenses paid that are a result of the injury or illness.

- **COMPENSATION BENEFITS:** You are entitled to 66-2/3 of your wages up to 100% of the state average weekly wage (as of the date of your injury) after 3 days from the date of your injury, if a physician states you are totally unable to work.

  ☐ If you have sustained a permanent impairment due to the industrial injury or disease, you are entitled to compensation based on the impairment rating as determined by a physician.

  ☐ If you are permanently totally disabled from working due to the industrial injury, you may need to apply at the Labor Commission, Division of Industrial Accidents, for a hearing to determine if benefits are due.

- **ADDITIONAL ASSISTANCE:** If you are unable to work due to an industrial injury and meet the program's requirements, you may be eligible for other assistance. Agencies you may wish to contact:

  ☐ Department of Workforce Services for food stamps, cash assistance, medical assistance, or employment assistance
  ☐ Social Security for total disability benefits

- **UNEMPLOYMENT BENEFITS:** If you are able to work, but have been terminated from your job, you need to apply at the nearest Department of Workforce Services employment office within 90 calendar days after you are released for full-time work by your doctor.

Contact your insurance carrier if problems occur during your injury regarding payment of medical bills or compensation payments. If you need to know who your employer's insurance carrier is, your may ask your employer or contact the Labor Commission, Division of Industrial Accidents.

For further information or assistance contact:
Labor Commission - Division of Industrial Accidents
160 East 300 South 3rd Floor, P.O. Box 146610, Salt Lake City, Utah 84114-6610
(801) 530-6800, 1 (800) 530-5090

THIS IS AN IMPORTANT DOCUMENT TO MAINTAIN FOR YOUR RECORDS

NOTICE
THAT

Employer: TRENDS INTERNATIONAL LLC
has complied with the provisions of the Workers' Compensation Act, Title §34A-2-101, Utah Code Annotated, 1997 (as amended), and the rules of the Labor Commission, and has insured the liability to pay the compensation and other benefits provided by said Act by insuring with Insurance Carrier: THE HANOVER INSURANCE COMPANY
Policy Number: WMW-9488045-02
Address for the above insurance carrier is 440 LINCOLN ST., PO BOX 15063, WORCESTER, MA 01615
Telephone number is 508-855-1000

WORKERS' COMPENSATION
IS INSURANCE WHICH PROTECTS YOU DURING WORK. IF YOU HAVE AN ON-THE-JOB INJURY OR OCCUPATIONAL DISEASE, IT WILL PAY FOR: HOSPITAL AND MEDICAL BILLS * TIME LOST FROM WORK * PERMANENT LOSS OF BODY FUNCTION * PROSTHETIC DEVICES * BURIAL BENEFITS IN DEATH CASES.

HOW TO REPORT AN ACCIDENT

1. Report the injury - no matter how slight - to your boss immediately. (You may lose your rights if your injury is not reported promptly.)

2. Ask your employer to fill out the employer's first report of injury form. A copy of this report is to be given to you and copies are to be sent to the Labor Commission and to the insurance company within seven (7) days of the accident.

3. If your employer has a first-aid room or company designated doctor, go there promptly for treatment. If not, go to a doctor of your choice.

4. Tell the doctor HOW, WHEN and WHERE the accident happened. The doctor will fill out a medical report form. Copies of the report are to be sent within seven (7) days of your visit to (1) the insurance company, (2) the Labor Commission and (3) you, the employee.

HOW TO START COMPENSATION

1. Ask your employer which insurance company pays workers' compensation for your company.

2. Ask your doctor to send a medical report to that insurance company.

3. Ask your employer to send a report of the accident to that insurance company.

4. Call the insurance company and ask them to start your workers' compensation benefits. The insurance company will require the doctor's report, employer's report, and may ask you to fill out a request for compensation.

REHABILITATION
IF YOU CANNOT RETURN TO WORK, YOU MAY BE ELIGIBLE FOR A REHABILITATION PROGRAM - CALL YOUR INSURANCE CARRIER AS LISTED ABOVE.

FRAUD
"For your protection, Utah Law requires the following to appear on this form: any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison."

STATE OF UTAH

LABOR COMMISSION
160 EAST 300 SOUTH, PO BOX 146610, SALT LAKE CITY, UT 84114-6610
(801)530-6800 -- (800)530-5090

If you want an Employee's Guide to Workers' Compensation or have questions, call the Labor Commission at the above listed numbers.

NOTE: This notice must be posted and kept continuously in a public and conspicuous place in the office, shop or place of business of the employer as per §34A-2-204, Utah Code Annotated, 1997.