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.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

***IMPORTANT**; Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First / Middle Initial / Last
2. DOB:
3. Age:
4. Male ☐ Female ☐
5. SS No.:
6. Address: No. & St. / City/Town
7. State:
8. Zip Code:
9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:
11. Occupation when injured:
12. Was this his/her regular occupation? If not, state regular occupation:
13. Wages per hr.:
14. No. hrs. worked per day:
15. No. days worked per week:
16. Average Weekly Earnings:
17. Was injured hired in N.H. ?
18. Date employment began:
19. Date & Time of Injury:
20. Date disability began:
21. Was injured paid in full for this day?
22. Date supervisor/employer was first notified:
23. Name of Person notified:
24. Location/Jobsite where accident occurred:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es):
27. Part(s) of body injured:
28. Estimated length of disability:
29. Has injured return to work?
30. If so, what date?
31. At what occupation or job?
32. Returned at: Full Duty: _____ Alternative/Light Duty: _____
33. Equipment causing injury:
34. Were safeguards in place?
35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: ☐ Care provide by Employer only (on-site): ☐ Emergency Care: ☐ Hospitalized: ☐
Other: (Outpatient): ☐ (Clinic): ☐ (Office Visit): ☐ (Other-explain): _____
37. Name of treating physician: / Name of treating hospital:
38. Has injured died?, If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:
40. Employers Federal ID:
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above:
43. City/State:
44. Zip:
45. Telephone Number:
46. Insurance Co. (**not agent**) or Self Insured Group:
47. Managed Care Program? ☐ Y or ☐ N. If yes, name Provider:
48. No. of Employees: Full-time: / Part-Time:
49. Is there a Written Safety Program **in force**?
50. Is there an **active** Safety Committee?
51. Business SIC Code
52. Type or Nature of Business in N.H.:
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title:
56. Employee Signature (**whenever** possible):
57. Date of this report:

White - Labor Department **Canary - Insurance Claims Office** **Pink - Employer's Copy**

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1 You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8a WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20,21). After you have completed and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.

2 You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23a.

3 You may not sue your employer as a result of a work-connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1 You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).

2 You are required to file an Employer's First Report of Injury or Occupational Disease, form No. 8 WC, with the Labor Commissioner, copy to the nearest claims office of your insurance carrier, on all occupational injuries or diseases resulting in one visit to a physician, other than a house physician, as soon as possible but no later than five days after the date of knowledge thereof (RSA 281-A:53, I).

3 You are required to report to the Labor Commissioner, copy as in 2 above, any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's Supplemental Report of Injury, form No. 13 WCA, as soon as possible, but no later than ten days after the date of knowledge thereof (RSA 281-A:53,I and II).

4 You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, 32.

5 All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employers may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.

6 You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE – Violation of the various provisions of the Workers' Compensation Law carries civil penalties, court fines, or both.

David M. Wihby
Deputy Labor Commissioner

James W. Craig
Commissioner of Labor

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A, as amended.

Name of Insurance Company
Or self-insurer:

THE HANOVER INSURANCE COMPANY

440 LINCOLN STREET
WORCESTER, MA 01653
508-855-1000

Name of Employer:

TRENDS INTERNATIONAL LLC

By Carol Kilgore, CPP 1-317-388-4007

260087431

Employer Identification No.
(If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the Employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire
WCP-1 (08-13)

ESTADO DE NEW HAMPSHIRE
LEY DE COMPENSACIÓN PARA TRABAJADORES
AVISO DE LA CONFORMIDAD

A LOS EMPLEADOS

1 Cerca le requieren (RSA 281-A:19) divulgar puntualmente a su patrón lesión o una enfermedad ocupacional, incluso si usted la juzga para ser de menor importancia. Forme No. 8a WCA, aviso de lesión accidental o la enfermedad profesional, se puede utilizar para ese propósito (RSA 281-A:20,21). Después de que usted la haya terminado y haya puesto a disposición él o ella, su patrón debe recibo del acknowlege firmando y dándole una copia.
2 Le dan derecho a los servicios de un médico. Este médico estará dentro de una red manejada del cuidado, si RSA inferior aplicable 281-A:23a.
3 Usted no puede demandar a su patrón como resultado de lesión o de una enfermedad trabajar-conectada por causa de su elegibilidad para las ventajas debajo de Workers' Ley De la Remuneración.

A LOS PATRONES

1 Le requieren exhibir este cartel de modo que esté de la ventaja posible más grande a sus empleadso (RSA 281-A:4).
2 Le requieren archivar un informe de Employer's primer de lesión o de la enfermedad profesional, WC de la forma No. 8, con la comisión de trabajo, copia a la oficina más cercana de las demandas de su portador de seguro, en todas las lesiones o enfermedades ocupacionales dando por resultado una visita a un médico, con excepción de un médico de la casa, cuanto antes pero no más adelante de de cinco días después de la fecha del conocimiento (RSA 281-A:53i).
3 Le requieren divulgar a la comisión de trabajo, copia como en 2 arriba, cualquier inhabilidad ocupacional, si total o parcial, de cuatro o más días (RSA 281-A:22), en un informe suplemental de Employer's de lesión, forma No. 13 WCA, cuanto antes, pero no más adelante de diez días después de la fecha del conocimiento (RSA 281-A:53, i e II).
4 Le requieren equipar, o haga ser equipado, los servicios médicos y del hospital razonables, el otro cuidado remediador o los tipos vocacionales del rehabilitación, y varios de pensión por invalidez, a un empleado dañado o lisiado de acuerdo con RSA 281-A:23, 25, 26, 28, 29, 31, 32.
5 Todos los patrones con empleados 5 o más a tiempo completo desarrollarán las oportunidades alternativas temporales del trabajo para los empleados dañados de acuerdo con RSA 281-A:23-b. Los patrones pueden ser obligados reinstalar a empleados que sostienen lesión compensable de acuerdo con RSA 281-A:25-a.
6 Le requieren obtener del portador identificado debajo de una fuente de las formas de la remuneración de todos los trabajadores requeridos. AVISO - la violación de las varias provisiones de la ley de la remuneración de los trabajadores lleva penas, multas de la corte, o ambas civiles.

David M. Wihby
Deputado Comisiónado de Trabajo

James W. Craig
Comisiónado de Trabajo

El patrón infrascrito da por este medio el aviso de la conformidad con todas las provisiones de la ley de la remuneración de los trabajadores y de las regulaciones administrativas de la comisión de trabajo del estado de New Hampshire conforme a los estatutos revisados anotados, capítulo 281-A, según la enmienda prevista.

Nombre de la compañía de seguros
O uno mismo-asegurador:
THE HANOVER INSURANCE COMPANY

440 LINCOLN STREET WORCESTER,
MA 01653 508-855-1000

Nombre del patrón:
TRENDS INTERNATIONAL LLC

Por Carol Kilgore, CPP 317-388-4007

260087431

No. De la Identificación Del Patrón.
(si desconocido, patrón del número a solicitar el IRS)

Este aviso se debe fijar visible en y sobre el lugar de Employer's o los lugares del negocio
Prescrito por la comisión de trabajo
Estado de New Hampshire
WCP-1 (08-13)