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.

Employee's Rights and Obligations

District of Columbia Workers Compensation Law

- You are required by law to promptly report your injury by filing DCWC Form 7, employee's Notice of Accidental Injury or Occupational Disease, with your employer and the Office of Workers' Compensation within 30 days of the date of injury or the date you have knowledge that the injury is related to your job.

- In order to preserve your right to workers' compensation benefits under the law, you must file a written claim on DCWC Form 7a, Employee's Claim Application, within 1 year after your injury, or within 1 year after the last payment of benefits. Benefits include indemnity payments for lost wages, medical services and treatment, and vocational rehabilitation.

- Failure to properly file the Notice of Accidental Injury or Occupational Disease, DCWC Form 7 or the Employee's Claim Application DCWC, Form 7a, may bar your right to future compensation. Copies of these forms and other pertinent information are available on the Department of Employment Services, Office of Workers' Compensation's web site. The web site address is listed below.

- You may not sue your employer as a result of a work-related injury or disease, the Workers' Compensation law is your exclusive remedy.

- You have the right to choose a treating physician. Once you choose a treating physician you may not change physicians unless you get approval from your employer's insurance company or the Office of Worker's Compensation. The medical treatment includes medical services, supplies, prosthetic devices, and prescriptions. The medical services include treatment by a dentist, osteopath, podiatrist and chiropractor.

- Compensation is not paid for the first 3 days of disability unless the disability exceeds 14 days. Compensation is paid at the rate of $66^{2/3}\%$ of your average weekly wage. Unless your employer controverts your right to compensation within 14 days after he has knowledge of the injury, the 1st installment of compensation becomes due on the 14^{th} day and must be paid within 14 days after it is due.

- You have the right to request an informal conference or a formal hearing on disputes arising on matters regarding your claim and you have the right to be represented by an attorney or other representative if you so desire.

- You may be entitled to vocational rehabilitation services if you are unable to return to the job you had prior to the injury.

- For injuries occurring on or after 4/16/99, temporary partial or permanent partial or permanent partial disability benefits will be limited to 500 weeks. Within 60 days of the expiration date, the claimant may petition for an extension of benefits up to 167 weeks beyond the 500-week cap.

- Your employer is required to advise you of your rights and obligations under the Workers' Compensation law and if you need further information, you may call the Office of Workers' Compensation on (202) 671-1000 or fax (202) 671-1929. The web address is http://does.dc.gov

District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 20011
(202) 671-1000

Warning: *It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of his/her's employees, but no later than ten days thereafter. Failure to file this form shall be subject to civil penalty not to exceed $1,000.

Date and time of Injury _____ am/pm? Day of the week? _____
Normal starting time _____ am/pm? If employee back to work, give date and time _____ am/pm?
At what wage? _____ If fatal, give date of death _____ (file supplement report)
Date of disability began? _____ am/pm? Was the injured pain in full for this day? _____
Was the injured given Form No. 7 DCWC? _____ Foreman _____
When did you or the foreman first learn of the injury? _____
Male _____ Female _____ DOB _____ Employee's Telephone No. _____
Occupation when injured? _____ Was this his/her regular occupation? _____
(Department or branch regularly employed) _____
Was the injured hired in DC? _____ How long employed by you? _____
Piece or time worker? _____ Hourly wage? _____ Hours worked/day _____
Daily wages _____ Days worked per week _____ Average weekly earnings _____
If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month: _____
Employer's principal business function in DC _____
Employer's Telephone No. _____ Insurance Policy No. _____
Location of plant or place where accident occurred: _____
On employer's premises? _____
Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: _____

Name of Witnesses _____
Nature and location of injury (Describe fully): _____

Attending Physician and Address (If Hospital Involved – Indicate):

_____
Name of Person Completing Form

_____
Name (Please Print or Type)

_____
Signature

_____
Official Position

DISTRICT OF COLUMBIA GOVERNMENT
OFFICE OF WORKER'S COMPENSATION
P.O. BOX 56098
WASHINGTON, D.C. 20011

(202) 671-1000

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Date of This Report

Employee Social Security No.

Employer Identification No.

Insurer No.

EMPLOYEE'S
NOTICE OF ACCIDENTAL INJURY OR OCCUPATION DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

NOTICE TO EMPLOYEE

YOU MUST FILE THIS REPORT WITHIN 30 DAYS AFTER YOU BECOME AWARE OF AN ACCIDENTAL INJURY OR OCCUPATIONAL DISEASE AND ITS RELATIONSHIP TO YOUR JOB. PART 1 SHOULD BE MAILED TO THE D.C. GOVERNMENT, OFFICE OF WORKERS' COMPENSATION AT THE ABOVE ADDRESS. PART 2 SHOULD BE MAILED OR DELIVERED TO YOUR EMPLOYER, AND PART 3 RETAINED FOR YOUR RECORDS. IN ORDER TO PRESERVE YOUR RIGHTS UNDER THE LAW, YOU MUST FILE A CLAIM FORM NO. 7a DCWC, A COPY OF WHICH CAN BE OBTAINED FROM YOUR EMPLOYER OR THE OFFICE OF WORKERS' COMPENSATION.

Date and Time of Injury: _____ am/pm?

Place where injury occurred: _____

Description of Injury: _____

_____

THIS IS TO NOTIFY YOU _____
(Employer)

THAT I _____ while in your employ, sustained an injury [ ] or contracted an occupational disease [ ] as described above, caused by:

_____

Treating Physician's Name and Address: _____

_____

_____
(Employee's Signature)

DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION

PO BOX 56098 • WASHINGTON, DC 20011 • (202) 671-1000 • (202) 671-1929 (fax)

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalities include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed it, you should mail it to the Office of Workers' Compensation at the above address, and to your employer.

2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 for information.

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

4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A DCWC, Employee's Claim Application, within one (1) year after your injury, or within (1) year after the last payment of benefits.

5. If you desire information regarding your rights and obligations prescribed by law, you may call your employer first. If you need further information you may call the Office of Workers' Compensation at (202) 671-1000.

6. The law gives you the right to be represented if you so desire.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have 1 or more employees.

2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.

3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, copy to the nearest claim office of your insurer, on all occupational injuries or disease, as soon as possible, but no later than 10 days after the date of knowledge thereof.

4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.

5. You are required to report to the Office of Workers' Compensation, and your insurer, and disability of more than 3 days which was not previously reported, as soon as possible, but no later than 10 days after the date of knowledge thereof.

6. 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.

7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website http://does.dc.gov

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations

NAME OF INSURANCE COMPANY

THE HANOVER INSURANCE COMPANY

NAME OF EMPLOYER

BY TRENDS INTERNATIONAL LLC

260087431

Employer ID Number
(if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT EMPLOYER'S PLACE(S) OF BUSINESS

FORM NO. 1 DCWC

Revised June, 2002