The Hanover Insurance Group

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 Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

Insurer File No.

1. EMPLOYER LOCATION:	**2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ SAME AS BLOCK 1
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ SAME AS BLOCK 3
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
5. EMPLOYEE INFORMATION:	**6. MEDICAL INFORMATION:**
SSN ☐ Male ☐ Female	Treatment Facility
Name	Address
Address	City, State, Zip
City, State, Zip	Phone Ext.
Phone / Date of Birth	**7. WITNESS INFORMATION:**
Occupation / Date Hired	Name Phone
State of Hire / Preferred Language of Employee: O English O Spanish O Portuguese O Other:	
8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - **REPORT WITHIN 48 HOURS** - Date of death	
Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR**	Complete address where accident occurred:
Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No	
If Yes, date employer first notified of medical treatment or time lost	
Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown	
Print Name of Report Preparer	Date Prepared / Phone & Extension
Print Name of Employer Contact Person OR ☐ Same as above	Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

DWC-01 (01/03) *For instructions visit our web site: www.dlt.ri.gov/wc*

STATE OF RHODE ISLAND
DEPARTMENT OF LABOR & TRAINING

This employer is subject to the provisions of the

WORKERS' COMPENSATION ACT

of the State of Rhode Island

Workers' Compensation Insurance Company:	THE HANOVER INSURANCE COMPANY
Adjusting Company:	
Telephone:	508-855-1000
Policy Effective Date:	05/15/2014

In accordance with Rhode Island General Law §28-32-1, the **employer must report** to the Director of Labor and Training **every personal injury sustained by an employee if the injury incapacitates the employee from earning full wages for at least three (3) days or requires medical treatment, regardless of the period of incapacity.** If the injury proves fatal, the report must be filed within forty-eight (48) hours. If not fatal, the report shall be made within ten (10) days of the injury.

An injured employee shall have the freedom to choose medical treatment initially. The employee's first visit to any facility under contract or agreement with the employer or insurer to provide priority care **shall not be considered** the employee's initial choice.

For more information about Workers' Compensation procedures and benefits, call the Education Unit at (401) 462-8100 and press option #1 or TDD (401) 462-8006. If you suspect fraud, contact the Fraud Prevention Unit at (401) 462-8100 and press option #7.

In accordance with Rhode Island General Law §28-29-13, this notice must be posted and maintained in conspicuous places where workers are employed.
Fines may be imposed for noncompliance.

DEPARTAMENTO DE TRABAJO Y ENTRENAMIENTO DEL ESTADO DE RHODE ISLAND

Esta empresa esta sujeta a las estipulaciones del

ACTA DE COMPENSACION DE TRABAJADORES

del Estado de Rhode Island

Seguro de Compensación de Trabajo THE HANOVER INSURANCE COMPANY

Compañía Ajustadora: _____

Teléfono: 508-855-1000 Fecha Efectiva de Póliza: 05/15/2014

De acuerdo con las Leyes Generales de Rhode Island §28-32-1, **las empresas tienen que reportarle** al Director de Trabajo y Entrenamiento **cada lesión personal reportada por un empleado si la lesión incapacita al empleado de ganar un sueldo completo por un mínimo de tres (3) días, o requiere tratamiento médico, sin importar el período de incapacidad.** Si la lesión es fatal, el incidente debe ser reportado dentro de cuarenta y ocho (48) horas. Si no es fatal, el incidente será reportado dentro de diez (10) días de la lesión.

Un empleado lesionado tiene la libertad de escoger al primer proveedor médico. La primera visita del empleado a cualquier centro de atención médico contratado por la empresa o la aseguradora, con la intención de facilitar atencíon inmediata, **no será considerado** el primer proveedor médico.

Para más información referente a la compensación para trabajadores a causa de accidentes de trabajo, procedimientos y beneficios, llame a la Unidad Educacional al (401) 462-8100 y apriete la opción #1 o TDD (401) 462-8006. Si usted sospecha de fraude, póngase en contacto con la Unidad de Prevención de Fraude al (401) 462-8100 y apriete la opción #7.

De acuerdo con las Leyes Generales de Rhode Island §28-29-13, este aviso debe ser colocado y mantenido en lugares visibles para los trabajadores. Las empresas que no cumplan con este requerimiento pueden ser sujetas a multas.