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.

Kathryn J. Barger
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:

Berkley Industrial Comp
3490 Independence Dr.
Birmingham, AL 35266

Name of Employer:

By _____

_____

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 (04-14)

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
Diputado Labor Comisión

George N. Copadis
Comisión 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 del patrón:

Nombre de la compañía de seguros
O uno mismo-asegurador:
Berkley Industrial Comp
P. O. Box 660847
Birmingham, AL 35266
(800) 448-5621

Por _____

_____
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 (1-99)

NEW HAMPSHIRE WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Employer's First Report of Injury or Occupational Disease (C-2)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's First Reports of Injury or Occupational Disease (FROI's) may be submitted to us online at: www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement (LAB 500)

The Wage Statement must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Wage Statement.

Do not delay reporting the Employer's First Report of Injury or Occupational Disease for completion of the Wage Statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

LAB 500

New Hampshire

Employer's First Report of Injury

Submission Date: _____

WEB-8WC –

NHDOL# -

EMPLOYEE INFORMATION					
Employee Name (First & Last)		**Gender**	**Hired Date**		**Hired in NH**
ID Type - Employee ID	**Date of Birth**	**Age**	**Occupation when Injured**		
Employee Address	**Telephone**	**Wages per Hour**	**Hrs per Day**	**Days per Week**	**Average Weekly Earnings**

INJURY INFORMATION				
Injury Date / Time	**Date Employer Notified of Injury**	**Location/Jobsite & Business Name where accident occurred**		
Disability Began Date				
Claim Type	**Full Wages Paid on Injury Date**			
Accident Description				
Body part Injured		**Cause of Injury**		
Nature of Injury		**Witness Name**	**Witness Phone**	
Returned to work?	**If so, what date?**	**If so, at what occupation?**	**If so, at what duty status?**	
Initial Treatment			**Initial Treatment Date**	
Name of Treating Physician		**Name of Treating Hospital**	**Has injured died? If so, what date**	

EMPLOYER INFORMATION			
Employer Name		**Employer FEIN**	**Industry Code**
Employer Contact Name	**Contact Phone Number**	**Employer Business Address**	
Managed Care Organization			
Leased Employee? Client Company		**OCIP/Wrap-Up Policy? Name of policy holder**	

INSURER INFORMATION			
Insurance Carrier	**Insurer Type**	**Policy Number**	**Telephone Number**

SUBMITTER INFORMATION			
Submitter Name	**Title of Submitter**	**Represents**	**Telephone Number**

LAB 500

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, NH 03301

WAGE SCHEDULE

Employee_____
(Name)

Date of hire_____ Wages per hour_____ Avg. wkly. earnings_____

Employer_____
(Name)

Address_____ _____ _____
(No.) (Street) (City – State)

EMPLOYER MUST FORWARD TO INSURANCE CARRIER A COPY OF THIS WAGE SCHEDULE OR A PRINTOUT OF GROSS WAGES NO LATER THAN EMPLOYEE'S FIFTEENTH DAY OF DISABILITY RESULTING FROM INDUSTRIAL ACCIDENT.PER LAB 506.02(b)

THIS WAGE SCHEDULE IS FOR 52 WEEKS PRIOR TO DATE OF INJURY AND MUST BE FILED WITH DEPARTMENT OF LABOR BY INSURANCE CARRIER TOGETHER WITH 9 WCA.

WEEK ENDING		1 GROSS WAGES (See Wages Definition)	WEEK ENDING		2 3 GROSS WAGES
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		

CarrierName_____ _____
(Employer's Signature)

Address_____
(Title)

Dept. Approval _____ Date _____

GROSS WAGES: In addition to money payments, means reasonable value of board, rent, housing, lodging, fuel or similar advantage received in the course of employment plus gratuities from others, but not including any sum paid by the employer to cover any special expenses entailed by the employee by the nature of his employment. Please provide a brief explanation for weeks with no wages. RSA 281-A:2, Par XV