

## Claim Notification Form:

Policy Number: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Contact Information:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Occurrence Information:

Date of Occurrence: \_\_\_\_\_

Location: \_\_\_\_\_

Description of Incident: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email completed forms to Hanover Claims Reporting  
Workers Compensation Claims: [wnewlosses@hanover.com](mailto:wnewlosses@hanover.com)  
All other: [firstreport@hanover.com](mailto:firstreport@hanover.com)