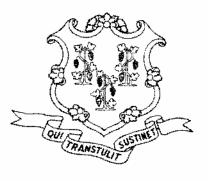
NOTICE TO EMPLOYEES



State of Connecticut Workers' Compensation Commission

Revised 10-01-2017

The Workers' Compensation Act (Connecticut General Statutes Chapter 568) requires your employer,

Family Support Team, LLC

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer."

An injury report by the employee is NOT an official written notice of claim for workers' compensation benefits; the Workers' Compensation Commission's Form 30C is necessary to satisfy this requirement.

NOTE: You must comply with P. A. 17-141 (see next box, below) when filing a compensation claim.

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _ Workers' Compensation Trust	t
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Address _	47 Barnes Industrial Road South	Telephone		(203) 678-0100	
City/Town	Wallingford	State	СТ	Zip Code	06492
Approved	Medical Care Plan 💢 Yes 📃 No				
The State of	of Connecticut Workers' Compensation Commiss	sion offic	e for t	his workplace is l	ocated at:

Address	999 Asylum Avenue	Telephone	(860) 566-4154

City/Town Hartford

Public Act 17-141 allows an employer the option to designate and post – "in the workplace location where other labor law posters required by the Labor Department are prominently displayed" and on the Workers' Compensation Commission's website [wcc.state.ct.us] – a location where employees must file claims for compensation.

If your employer has listed a location below, you <u>MUST</u> file your compensation claim there. When filing your claim, you are also required – by law – to send it by certified mail.

If blank below, ask your employer where to file your claim.

Employer Name Family Support Team, LLC	
CEO Address <u>96 Skyline Drive</u>	Telephone 614-6062
City/Town East Hartford	State CT Zip Code 06118

THISNOTICE MUST BEIN TYPE OF NOT LESS THAN TEN
POINT BOLD-FACE AND POSTED IN A CONSPICUOUS
PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE
TO POST THIS NOTICE WILL SUBJECT THE EMLOYER
TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted:

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company, or the Workers' Compensation Commission (1-800-223-9675).

_____ State ____ Zip Code ____06105