

## Need to file a Workers' Compensation claim?

We make the process easy and stress free.

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At Great American, we understand that filing a claim can be upsetting and stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.



*Call our reporting center*

**877-836-1555**



***Preregistration Required***

*To set up and gain access to our online system*

Call **860-683-7078**

*Once registered, report a claim online*

**www.Netclaim.net**



So that you're best prepared to report the claim,  
please see the reverse side for information we  
may request from you.



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We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

Great American Insurance Group, 301 E. Fourth St., Cincinnati, OH 45202. Policies are underwritten by Great American Insurance Company, Great American Assurance Company, Great American Alliance Insurance Company, Great American Insurance Company of New York, Great American Security Insurance Company and Great American Spirit Insurance Company, authorized insurers in all 50 states and DC. The Great American Insurance Group eagle logo and the word marks Great American® and Great American Insurance Group® are registered service marks of Great American Insurance Company. © 2016 Great American Insurance Company. All rights reserved. 4642-ALT-1 (6/16)



### **Accident Information:**

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

### **Employee Information:**

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

### **Medical Provider Information:**

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

*After you report a claim, the Claim Reporting Center:*

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.



Alternative Markets  
Claim Reporting Center:

**877-836-1555**

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## CALL PREPARATION GUIDE FOR WORKERS' COMPENSATION CLAIMS

Gathering complete and accurate information is the first step toward a fair and timely resolution of any claim.

When you contact the Alternative Markets **Claim Reporting Center** to report a claim, you will be asked a series of questions needed to complete the First Report of Injury. The items listed on the reverse side will assist with your preparation.

Once the data is collected by the **Claim Reporting Center**:

- Your claim will be assigned to an Alternative Markets Claim professional who will contact you to acknowledge the claim and initiate the process.
- You and your employee will receive an acknowledgment letter with the claim number and information needed to contact us directly.
- The **Claim Reporting Center** provides you with a copy of the First Report of Injury.
- This report will be sent directly to the state either by mail or electronic submission, based on your state's requirements.

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it to 877-836-1555.

We are here 24/7!



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Alternative Markets



Alternative Markets  
Claim Reporting Center:

**877-836-1555**

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## CALL PREPARATION GUIDE FOR WORKERS' COMPENSATION CLAIMS

**POLICY NUMBER:** \_\_\_\_\_

**ACCIDENT INFORMATION:**

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

**EMPLOYEE INFORMATION:**

- Name, physical home address, county, and home phone
- Date of birth, social security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

**MEDICAL PROVIDER INFORMATION:**

- Name of clinic/doctor's office where employee treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

# Instructions for Completing the First Report of Injury

Please read all pages

This form is “fillable.” That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the “Employee’s Name” box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, do type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The “Injury Description”, “Name of Witness”, and “Name of Doctor” fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

To clear or delete all the information you have typed onto the form, click on the red “Clear Entire Form” button. To change the information in one field, use the backspace or delete key.

See instructions on reverse side before completing form.

**COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION**

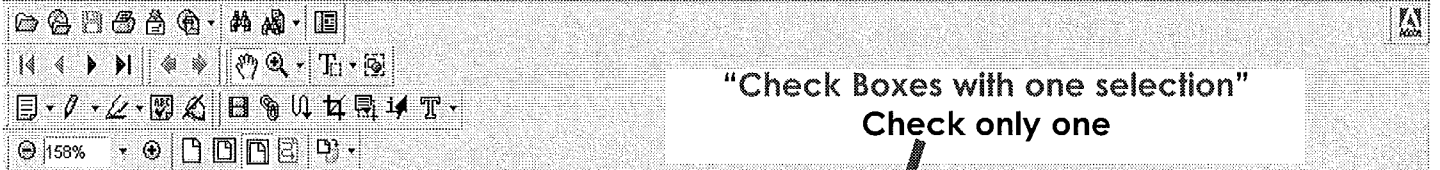
**EMPLOYER'S FIRST REPORT OF INJURY**

**Clear Entire Form**

Employee's name (first, middle, last)		Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ( )	OSHA Log #
Employee's street address			City	State	Zip code
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> UNKNOWN	Employer's name	Federal ID #	Employer's phone # ( )	For Division use only
Employer's mailing address		City	State	Zip code	SOI
Average weekly wage at time of injury \$ (see instructions on reverse side)	Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Room <input type="checkbox"/> Meals <input type="checkbox"/> Health insurance	Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Room <input type="checkbox"/> Meals <input type="checkbox"/> Health insurance		NOI	Coder
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are wages continued per C.R.S. 8-42-124? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Injury/Illness date / / <small>(See instructions)</small>	Time employee began work a.m. p.m.	Injury time a.m. p.m.	Last day worked / /	Date employer notified / /	Date disability began / /
				Date returned to work / /	

**"Clear Entire Form" button  
Clears all information at once**

**"Check Box"  
Click in box**



**"Check Boxes with one selection"  
Check only one**

Average weekly wage at time of injury \$ _____ <small>(see instructions on reverse side)</small>		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		NOI Coder
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Injury/Illness date	Time employee began work	Injury time	Last day worked	Date employer notified	Date disability began	Date returned to work
<b>"Gray Border"</b>						
<b>Enter information and tab to next field</b>						
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death			Injury occurred because of <input type="radio"/> Intoxication <input type="radio"/> Safety violation <input type="radio"/> Not applicable	
Tell us the part of body that was affected				Tell us the nature of the injury/illness <sup>2</sup>		
What was the employee doing just before the accident occurred? <sup>3</sup>						
Tell us how the injury occurred <sup>4</sup>				What object or substance directly harmed the employee? <sup>5</sup>		
Did injury occur on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code		Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room		Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

See instructions on reverse side before completing form.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**EMPLOYER'S FIRST REPORT OF INJURY**

Employee's name (first, middle, last)		Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's home phone # ( )		OSHA Log #
Employee's street address				City	State	Zip code	
Birth date / /	Marital status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Unknown	Date of hire / /		Occupation	Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Other <input type="checkbox"/> Unknown		For Division use only
Employer's name			Employer's Federal ID #		Employer's phone # ( )		SOI
Employer's mailing address				City	State	Zip code	POB
Average weekly wage at time of injury \$ (see instructions on reverse side)		Check box if employee receives <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance		Check if these benefits are included in AWW <input type="checkbox"/> Tips <input type="checkbox"/> Meals <input type="checkbox"/> Room <input type="checkbox"/> Health insurance			NOI Coder
Is the employer self-insured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were full wages paid for the DOI? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are wages continued per C.R.S. 8-42-124? <sup>1</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No			
Injury/Illness date / / (See instructions on reverse side)	Time employee began work a.m. p.m.	Injury time a.m. p.m. unknown	Last day worked / /	Date employer notified / /	Date disability began / /	Date returned to work / /	
Did injury cause death? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, date of death / /	Name, relationship, and address of closest dependent if injury caused death			Injury occurred because of <input type="checkbox"/> Intoxication <input type="checkbox"/> Safety violation <input type="checkbox"/> Not applicable		
Tell us the part of body that was affected				Tell us the nature of the injury/illness <sup>2</sup>			
What was the employee doing just before the accident occurred? <sup>3</sup>							
Tell us how the injury occurred <sup>4</sup>				What object or substance directly harmed the employee? <sup>5</sup>			
Did injury occur on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Injury site address/ 9-digit zip code		Initial treatment (check one) <input type="checkbox"/> None <input type="checkbox"/> Emergency room <input type="checkbox"/> Minor on-site <input type="checkbox"/> Hospital >24 hrs <input type="checkbox"/> Clinic/hospital		Was the employee hospitalized overnight as an in-patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of witnesses				Name of employer representative notified			
Name and address of treating doctor or other health care professional				Name and address of facility where treated			
Completed by (name)		Title		Phone # ( )		Date completed / /	
<b>The following is to be completed by the insurer prior to filing with the Division of Workers' Compensation.</b>							
Name of insurance company				Address			
Name of third party administrator (if applicable)				Address			
Adjuster name				Adjuster phone #			
Policy #	Carrier claim #		Date insurer received first report / /		Block #	Adj. Code	



## INSTRUCTIONS

### This form contains all items requested on OSHA Form No. 301, "Injuries & Illnesses Incident Report"

#### General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

#### Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer *if the employer will not be paying such benefit during the period of disability*.
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the *Average weekly wage at time of injury* field.

#### Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

#### Notes

Are Wages continued per C.R.S. 8-42-124?<sup>1</sup>

(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

- 1 Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness<sup>2</sup>; What was the employee doing just before the accident occurred?<sup>3</sup>; What happened?<sup>4</sup>; What object or substance directly harmed the employee?<sup>5</sup>)

- 2 Be more specific than "hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 3 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
- 4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

#### Notices

**You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.**

**C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."**

# **WARNING**

**IF YOU ARE INJURED ON THE  
JOB, WRITTEN NOTICE OF YOUR  
INJURY MUST BE GIVEN TO  
YOUR  
EMPLOYER WITHIN FOUR WORK-  
ING DAYS AFTER THE ACCIDENT,  
PURSUANT TO SECTION 8-43-102  
(1) AND (1.5), COLORADO RE-  
VISED STATUTES.**

**IF THE INJURY RESULTS FROM  
YOUR USE OF ALCOHOL OR  
CONTROLLED SUBSTANCES,  
YOUR WORKERS' COMPENSA-  
TION  
DISABILITY BENEFITS MAY BE  
REDUCED BY ONE-HALF IN  
ACCORDANCE WITH SECTION 8-  
42-112.5, COLORADO REVISED  
STATUTES.**

## **AVISO**

**SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).**

**SI EL ACCIDENTE RESULTA DEBIDO AL USO DE ALCOHOL O UNA SUSTANCIA CONTROLADA, SUS BENEFICIOS DE LA INCAPACIDAD DE LA COMPENSACIÓN DE LOS TRABAJADORES PUEDEN SER REDUCIDOS POR UN MEDIO EN ACUERDO DE LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-42-112.5.**