Need to file a Workers' Compensation claim?

We make the process easy and stress free.

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.



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, 0H 45202. Policies are underwritten by Great American Insurance Company, Great American Alsurance Company, Great American Alsurance 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.



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!





CALL PREPARATION GUIDE FOR

Workers' Compensation Claims

POLICY NUMBER:			
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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

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WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

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ia ia					Insured Report No.										
General					Employer's Location Address (if different)						ition	No.			
	Sic Code	Employer FEIN											Pho	ne No).
Carrier/Claims Admin	Carrier (Name, Address & Phone No		Policy Period Claims Admin (Name, Address & Phone Number) To Check if self insured												
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Legal Name (Last, First, Middle) Birth Date Social Security Number Date Hired											State	e of Hir	e		
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Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (2/98)

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WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

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arrier/C	Carrier FEIN	Policy Number	er or Self-In	sured Nu	mber		Adm	ninistrat	or FEIN						
ပိ	Agent Name & Code Number														
	Legal Name (Last, First, Middle) Birth Date Social Security Number Date Hired Sta									Stat	ate of Hire				
9	Address (Incl. Zip)	Marita J	al Status Unmarried/ Single/Div.	Title											
Employee			Femal			Married Separated	Employ	ment S	atus						
Emp	Phone	ents [Unknown	NCCI C	lass Co	de								
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	\$ D W	eek 🔲	Other	#	Hrs Worker	d per Day	Did Sala	ary Con	tinue?		Yes		N	0	
		te of Injury Illness	Time Occurred				Date I	Date Er	mployer Notified	i i	Date Bega	Disab n	ility		
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WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

Employer (Name & Address incl. zip)									C	arrie	r/Administr	ator C	laim Numl	per	Report I	ourpo	se Co	ode					
										Ju	urisd	iction	Juris	sdiction Cl	aim No).							
2										In	sure	d Report N	lo.										
General										Employer's Location Address (if different)							Loc	atic	n No	0.			
	Sic Code			Emp	loyer F	EIN													Phone No.				
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_	Carrier (Name, Addr	ress	& Phone	Number)					Po	olicy	Period		Claims Ad	min (Na	ame, Add	ress 8	& Pho	ne Nui	nbe	er)	•	
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	Legal Name (Last, First, Middle) Birth Date Social Se								,					Hired			State	e of H	ire				
ď	Address (Incl. Zip) Se									Marital Status Occupation/Job Title Unmarried/ Single/Div.													
Employee							emal Jnkno				Ма	rried parated	Emp	loyment S	tatus								
Ē	Phone No. of De																						
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	\$ Time Employee	_	AM	Week Date of		Time	Other		# Hrs			•		Salary Cor				Yes		_	No		
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	Did Injury/Illness Exp Premises?	posu	ire Occui	r on Empl	oyer's	Ye			Туре	of I	llnes	s/Injury Co	y Code Part of Body Affected Code										
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	How injury or illness/a that directly injured th	/abn he e	ormal he mployee	alth cond or made	ition oc the em	curred. oloyee i	Desci ill.	ribe th	e seq	uenc	ce of	events and	d inclu	de any obj	ects or	substanc	es	Caus Code	e of In	ury			
	Date Returned to Wo	ork		If Fa	atal, Da	te of De	eath			1	Wer	e Safeguar	ds or S	Safety Equ	ipment	Provided	1?		Yes	E] [N o	
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NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

		Employer
Date		
	By	
		Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.

Employer's Supplemental Report

Employer: Fill out this form in duplicate. Mail copy to Industrial Commission (P.O. Box 83720, Boise, Idaho 83720-0041) and the original to your workers' compensation insurer at the following times:

- 1. Upon termination of disability (regardless of length of time disabled for work).
- 2. At the end of 60 days from the date disability began if employee is disabled that long.

Any employer who fails to make this report upon termination of the disability of one of his insured employees and (if the disability extends beyond a period of 60 days) at the end of that period is subject to a penalty not to exceed \$500.00.

Name of injured employee:	Address where mail should be sent:
Date of injury:	Date disability began:
Were wages paid for the day the disability began? Yes No	What wages, if any, have been paid during the period of disability?
Had the injured employee returned to work? Yes No	If so, on what date was he re-employed?
	At what daily wage?
At light or regular work? Light duty Regular work	If re-employed at less wages than received before the injury, give reason:
Give date the injured employee recovered sufficient	ntly to return to regular work:
THE ABOVE STATEMENTS ARE CO (The employee MUST NOT sign this form BEF work disability ceases)	
	Employer
Signature of injured employee	Signature of Authorized Agent
Data of this remort	Address

AVISO

RESPECTO A EL SEGURO DE COMPENSACIÓN PARA TRABAJADORES

TODOS LOS TRABAJADORES EMPLEADOS POR EL SUSCRITO SON, POR LA PRESENTE, NOTIFICADOS QUE EL PATRÓN HA CUMPLIDO CON LA LEY CON RESPECTO A ASEGURAR EL PAGO DE COMPENSACIÓN A LOS EMPLEADOS Y SUS DEPENDIENTES, DE ACUERDO CON LAS PROVISIONES DE LA LEY DE COMPENSACIÓN PARA TRABAJADORES.

		Patrón
Fecha		
	Por	Agente Autorizado del Patrón

Un empleado que recibe un daño en un accidente tiene que notificar immediatamente a su mayordomo o mayordoma, superintendente o a la persona suscrita, quien proveera atención médica.

Reclamación para compensación tiene que ser hecha por escrito y entregada al patrón. Formas explicando el daño y reclamando compensación serán proveidas por el patrón; por el fiador,

o con solicitud, por La Comisión Industrial en Boise, Idaho.