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

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

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!

GREAT AMERICAN INSURANCE GROUP
Alternative Markets

Alternative Markets Claim Reporting Center:

877-836-1555

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

Print Form

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)	Carrier/Administrator Claim Number	Report Purpose Code
	Jurisdiction	Jurisdiction Claim No.
	Insured Report No.	
	Employer's Location Address (if different)	Location No.
Sic Code / Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period / To / ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Legal Name (Last, First, Middle)	Birth Date	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
Phone	No. of Dependents		Employment Status	
			NCCI Class Code	

Wage Rate $	☐ Day ☐ Week	☐ Month ☐ Other	# Days Worked/WK / # Hrs Worked per Day	Full Pay for Date of Injury? ☐ Yes ☐ No / Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work	☐ AM ☐ PM	Date of Injury or Illness	Time Occurred	☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began

Employer Contact Name/Phone Number		Type of Illness/Injury	Part of Body Affected
Did Injury/Illness Exposure Occur on Employer's Premises?	Yes ☐ No ☐	Type of Illness/Injury Code	Part of Body Affected Code
Department or location where accident or illness exposure occurred		All Equipment, Materials, or Chemicals Employee Using upon Occurrence	
Specific Activity Employee Engaged in at Time of Occurrence		Work Process the Employee Was Engaged in at Time of Occurrence	
How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill.			Cause of Injury Code
Date Returned to Work	If Fatal, Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No	
		Were they used? ☐ Yes ☐ No	

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
		0 ☐ No Medical Treatment 1 ☐ Minor: By Employer 2 ☐ Minor Clinic/Hosp 3 ☐ Emergency Care 4 ☐ Hospitalized – 24 hr. 5 ☐ Anticipated Major Med/Lost Time

Other

Signature of Injured Employee, or Signature on File, Date	Witness to Accident (Name & Phone Number)	
Date Administrator Notified / Date Prepared	Preparer's Name & Title	Preparer's Phone Number

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)

Print Form

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)	Carrier/Administrator Claim Number	Report Purpose Code
	Jurisdiction	Jurisdiction Claim No.
	Insured Report No.	
	Employer's Location Address (if different)	Location No.
Sic Code / Employer FEIN		Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period / To / ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Legal Name (Last, First, Middle)	Birth Date	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
			Employment Status	
Phone	No. of Dependents		NCCI Class Code	
Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other	# Days Worked/WK / # Hrs Worked per Day		Full Pay for Date of Injury? ☐ Yes ☐ No / Did Salary Continue? ☐ Yes ☐ No	

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury or Illness	Time Occurred ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
Employer Contact Name/Phone Number		Type of Illness/Injury		Part of Body Affected	
Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No		Type of Illness/Injury Code		Part of Body Affected Code	
Department or location where accident or illness exposure occurred		All Equipment, Materials, or Chemicals Employee Using upon Occurrence			
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Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
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	Employer's Location Address (if different)	Location No.
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Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period / To / ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Legal Name (Last, First, Middle)	Birth Date	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
Phone	No. of Dependents		NCCI Class Code	

Wage Rate $	☐ Day ☐ Week	☐ Month ☐ Other	# Days Worked/WK / # Hrs Worked per Day	Full Pay for Date of Injury? ☐ Yes ☐ No / Did Salary Continue? ☐ Yes ☐ No

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Employer Contact Name/Phone Number		Type of Illness/Injury	Part of Body Affected
Did Injury/Illness Exposure Occur on Employer's Premises?	☐ Yes ☐ No	Type of Illness/Injury Code	Part of Body Affected Code
Department or location where accident or illness exposure occurred		All Equipment, Materials, or Chemicals Employee Using upon Occurrence	
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Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
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TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

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.

I.C. Form 14

File No.

ORIGINAL
Mail to
Surety

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.

<table>
<tr><td>Name of injured employee:</td><td>Address where mail should be sent:</td></tr>
<tr><td>Date of injury:</td><td>Date disability began:</td></tr>
<tr><td>Were wages paid for the day the disability began?
☐ Yes ☐ No</td><td>What wages, if any, have been paid during the period of disability?</td></tr>
<tr><td rowspan="2">Had the injured employee returned to work?
☐ Yes ☐ No</td><td>If so, on what date was he re-employed?</td></tr>
<tr><td>At what daily wage?</td></tr>
<tr><td>At light or regular work?
☐ Light duty ☐ Regular work</td><td>If re-employed at less wages than received before the injury, give reason:</td></tr>
<tr><td colspan="2">Give date the injured employee recovered sufficiently to return to regular work:</td></tr>
</table>

THE ABOVE STATEMENTS ARE CORRECT
(The employee MUST NOT sign this form BEFORE the work disability ceases)

_____
Employer

_____
Signature of injured employee

_____
Signature of Authorized Agent

Date of this report _____

Address _____

PARA EL PATRON: ESTE AVISO DEBE SER PUESTO EN UN LUGAR CONSPICUO EN SU SITIO DE NEGOCIO.

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.