

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, 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

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!



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

MAIL TO:
WORKERS' COMPENSATION INSURER

Employee Social Security Number

Employer UI Account Number

Employer Federal ID Number

**EMPLOYER REPORT
OF
INJURY/ILLNESS**

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
☐ Injury resulted in death
☐ Amputation or disfigurement
☐ Possible dispute
☐ Lump Sum Compromise/Settlement
☐ Other

☐ Medical only
(DO NOT mail copy to OWCA)

1. Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Normal Starting Time Day of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	4. If Back to Work - Give date MM/DD/YY	5. At same wage? <input type="checkbox"/> Yes <input type="checkbox"/> No	DO NOT WRITE IN THIS COLUMN
6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received	
10. Employee Name First Middle Last	11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone # ()	Name:		
13. Address and Zip Code			14. Parish of Injury	State-Parish	
15. Date of Hire	16. Date of Birth	17. Occupation	18. Dept/Division Employed	Occupation	
19. Place of Injury-Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, Indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.					Part of Body
					Source
					Event
					NCCI
22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)					24. If Occ. Disease-Give Date Diagnosed
25. Physician and Address			26. If Hospitalized, give name & address of facility		
27. Employer's Name			28. Person Completing This Report - Please print		
29. Employer's Address and Zip Code			30. Employer's Telephone Number ()		
31. Employer's Mailing Address-If Different From Above			32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.		
33. Wage Information (optional) Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other. The average weekly wage was \$_____ per week.					

LWC-WC-1007 Insurer Name:
Rev: 07/08 Phone:
Address:

Insurer's Administrator or Representative:
Phone:
Address:

Download Employer's Certificate of Compliance

MAIL TO:
WORKERS' COMPENSATION INSURER

Employee Social Security Number

Employer UI Account Number

Employer Federal ID Number

**EMPLOYER REPORT
OF
INJURY/ILLNESS**

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability
☐ Injury resulted in death
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☐ Possible dispute
☐ Lump Sum Compromise/Settlement
☐ Other

☐ Medical only
(DO NOT mail copy to OWCA)

1. Date of Report MM/DD/YY	2. Date / time of Injury MM/DD/YY Time <input type="checkbox"/> AM <input type="checkbox"/> PM	3. Normal Starting Time Day of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	4. If Back to Work - Give date MM/DD/YY	5. At same wage? <input type="checkbox"/> Yes <input type="checkbox"/> No	DO NOT WRITE IN THIS COLUMN
6. If Fatal Injury, Give Date of Death MM/DD/YY	7. Date Employer Knew of Injury MM/DD/YY	8. Date Disability began MM/DD/YY	9. Last Full Day Paid MM/DD/YY	Date Received	
10. Employee Name First Middle Last			11. <input type="checkbox"/> Male <input type="checkbox"/> Female	12. Employee Phone # ()	Name:
13. Address and Zip Code				14. Parish of Injury	State-Parish
15. Date of Hire	16. Date of Birth	17. Occupation		18. Dept/Division Employed	Occupation
19. Place of Injury-Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. If No, Indicate Location-Street, City, Parish and State			Nature
21. What work activity was the employee doing when the injury occurred? (Give weight, size and shape of materials or equipment involved). Explain what employee was doing with them. Indicate if correct procedures were followed.					Part of Body
					Source
					Event
					NCCI
22. What caused injury to happen? (Describe fully the events which resulted in injury or disease. Explain what happened and how it happened. Name any objects or substances involved and explain how they were involved. Give full details on all factors which led to or contributed to this injury or illness.)					
23. Part of Body Injured and Nature of Injury or Illness (ex. left leg; multiple fractures)					24. If Occ. Disease-Give Date Diagnosed
25. Physician and Address				26. If Hospitalized, give name & address of facility	
27. Employer's Name				28. Person Completing This Report - Please print	
29. Employer's Address and Zip Code				30. Employer's Telephone Number ()	
31. Employer's Mailing Address-If Different From Above				32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc.	
33. Wage Information (optional) Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other. The average weekly wage was \$_____ per week.					

LWC-WC-1007 Insurer Name:
Rev: 07/08 Phone:
Address:

Insurer's Administrator or Representative:
Phone:
Address:

Download Employer's Certificate of Compliance

Compensacion del Trabajador

Reportando de lesiones/heridas

Usted debe reportar a su empleador cualquier enfermedad ocupacional o lesión personal que esté relacionada con el trabajo, aún y cuando usted piense que es insignificante o menor.

Enfermedades ocupacionales o muerte

En caso de enfermedad ocupacional, no todos los reclamos son elegibles a menos que el empleado haga el reclamo con su empleador dentro del siguiente año de la fecha que:

1. La enfermedad se manifiesta por si sola.
2. El empleado está desabilitado como resultado de esta enfermedad.
3. El empleado sabe o tiene razones poderosas para creer que la enfermedad está relacionada con su ocupación.

En caso de muerte que aparece como resultado de una muerte ocupacional, no todos los reclamos son válidos solamente que el o los dependientes hagan un reclamo con el empleador del empleado muerto dentro de 1 (uno) año de:

1. La fecha de muerte.
2. La fecha que el reclamante tenga suficientes pruebas para creer que la muerte fué resultado de muerte ocupacional.

Aviso para reclamar o solicitar

En caso de lesiones o muerte causadas por accidente relacionados al trabajo o accidentes, el empleado lesionado o cualquier persona que haga un reclamando y para tener derecho a la compensación ya sea como reclamante o como el representante de la persona que está reclamando para poder tener derecho a la compensación, deberá dar aviso a su empleador dentro de los 30 días siguientes después de la lesión. Si el aviso no es dado dentro de los siguientes 30 días, ningún pago será hecho por dicha lesión o muerte. En adición, cualquier acción fraudulenta por el empleador, empleado o cualquier otra persona con el propósito de obtener o buscar cualquier beneficio o pagos a través del Programa de Compensación de Trabajadores dicha persona está sujeta a cargos criminales al igual que a responsabilidad civil.

El aviso arriba mencionado deberá ser presentado con el empleador en la dirección que aparece en el lado derecho.

Un aviso dado no deberá ser invalidado o mantenerse invalidado por cualquier inexactitud en el tiempo, lugar, naturaleza o causa de la lesión al momento de hacer la declaración, o de otra manera, solamente si se demuestra que el empleador fué mal informado para con esto perjudicar. El fallar o faltar de notificar es posible que no perjudique al empleado si el empleador sabe del accidente o si el empleador no es perjudicado por la tardanza o por faltar de hacer la notificación.

Medicos

En caso que usted es lesionado, usted tiene el derecho de elegir al médico para su tratamiento. El empleador puede escoger otro médico y hacer arreglos para otro exámen para el cual usted será requerido para atender.

Reclamo formal

Para poder preservar sus derechos a los beneficios bajo la Ley de Compensación de los Trabajadores del estado de Louisiana, usted debe hacer un reclamo formal con la oficina administrativa del Programa de la Ley de Compensación de los Trabajadores dentro del siguiente año después del accidente si no se han hecho pagos o dentro del año después del último pago de beneficios.

Información

Si usted desea cualquier información relacionada a sus derechos y a los beneficios a los cuales usted tiene derecho descritos por la ley, usted puede llamar o escribir a la Office of Worker's Compensation Administration, PO Box 94040, Baton Rouge, Louisiana 70804-9040 o al teléfono (225) 342-7555.

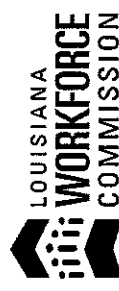
Nombre y Dirección de la Compañía de Seguros

La notificación deberá ser dada ya sea llevándola personalmente o enviándola por correo certificado regresando o regresar el recibo solicitado a:

Representante del empleador

Empleador

R.S. 23:1302 manifiesta que éste aviso debe estar puesto en un lugar visible y conveniente en el negocio del empleador.
Revisado Mayo 2003



RECORD OF OCCUPATIONAL INJURY/ILLNESS INCIDENCE RATES

INSURED
LOCATION
YEAR

COMPARISON INCIDENCE RATES	YEAR:	
	S.I.C. Code:	B.L.S. N.S.C.
	Recordable Cases	
	Lost Workday Cases	
Lost Workdays		

MONTH	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Number of Employees												
Hours Worked												
Cumulative Hours Worked												
Recordable Cases												
Cumulative Recordable Cases												
Lost Workday Cases												
Cumulative Lost Workday Cases												
Lost Workdays												
Cumulative Lost Workdays												
Monthly Incidence Rate Recordable Cases												
Cumulative Incidence Rate Recordable Cases												
Monthly Incidence Rate Lost Workday Cases												
Cumulative Incidence Rate Lost Workday Cases												
Monthly Incidence Rate Lost Workdays												
Cumulative Incidence Rate Lost Workdays												

INSURED: _____ LOCATION: _____ YEAR OF 20 _____

YEAR OF 20

LOST WORKDAYS

[illegible]

N.S.C. Industry average rate

**EMPLOYEE
CERTIFICATE OF COMPLIANCE**

You must submit this form to your employer's workers' compensation insurer or to your employer within 14 days of its receipt. Your workers' compensation benefits may be suspended if you do not timely submit this Certification. You would be entitled to all suspended benefits after this Certification is provided to your insurer, if you are otherwise eligible for benefits.

It is unlawful for you to work and receive workers' compensation disability benefits, except for supplemental earnings benefits. Supplemental earnings benefits are paid when an employee is able to work, but is unable to earn 90% or more of his pre-injury wages as a result of a job related accident. As an injured worker, you must notify your employer or insurer of the earning of any wages, changes in employment or medical status, receipt of unemployment benefits, receipt of social security benefits and receipt of retirement benefits. If you receive benefits for more than 30 days, you will be required to certify your earnings to your insurer quarterly.

It is unlawful for you to receive workers' compensation indemnity disability benefits and unemployment benefits at the same time, except for permanent partial disability benefits. Permanent partial disability benefits are paid solely for amputation or for anatomical loss of use of a body part or function. If you violate this provision, you may be fined up to \$10,000, imprisoned up to 90 days, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined, imprisoned, or both, as follows:

<u>Unlawful Benefits Paid or Claimed</u>	<u>Fine</u>	<u>Imprisonment</u>
\$10,000 or more	up to \$10,000	up to 10 years, with or without hard labor
\$2,500 or more but less than \$10,000	up to \$ 5,000	up to 5 years, with or without hard labor
less than \$2,500	up to \$500	up to 6 months

In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000 and may forfeit your right to receive workers' compensation benefits.

EMPLOYEE CERTIFICATION

I certify that I understand the contents of this entire document, and that I understand I am held responsible for this information. I certify my compliance with the above stated requirements regarding receipt of workers' compensation benefits.

_____ Print Name	_____ Signature	_____ Social Security Number	_____ Date
_____ Address	_____ City	_____ State / Zip	() Phone Number

Note: Only one copy is required per case from the employee.

Please mail this form to your employer or your employer's insurer.

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_____ Address	_____ City	_____ State / Zip	() Phone Number

Note: Only one copy is required per case from the employee.

Please mail this form to your employer or your employer's insurer.

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of \$500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to \$10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than \$500, or imprisoned with or without hard labor for not more than one year, or both.

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EMPLOYER CERTIFICATION

I certify that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)

Signature Date

Company Name

Company Address

()

Phone Number

Insurance Policy Number

Employee Name

- -

Employee Social Security Number

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Signature Date

Company Name

Company Address

() _____
Phone Number

Insurance Policy Number

Employee Name

Employee Social Security Number

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Preparer Name (PRINT)

Signature Date

Company Name

Company Address

() _____
Phone Number

Insurance Policy Number

Employee Name

Employee Social Security Number

workers' compensation



Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

- 1 the disease manifests itself.
- 2 the employee is disabled as a result of the disease.
- 3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

- 1 the date of death.
- 2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

Employer Representative

Employer

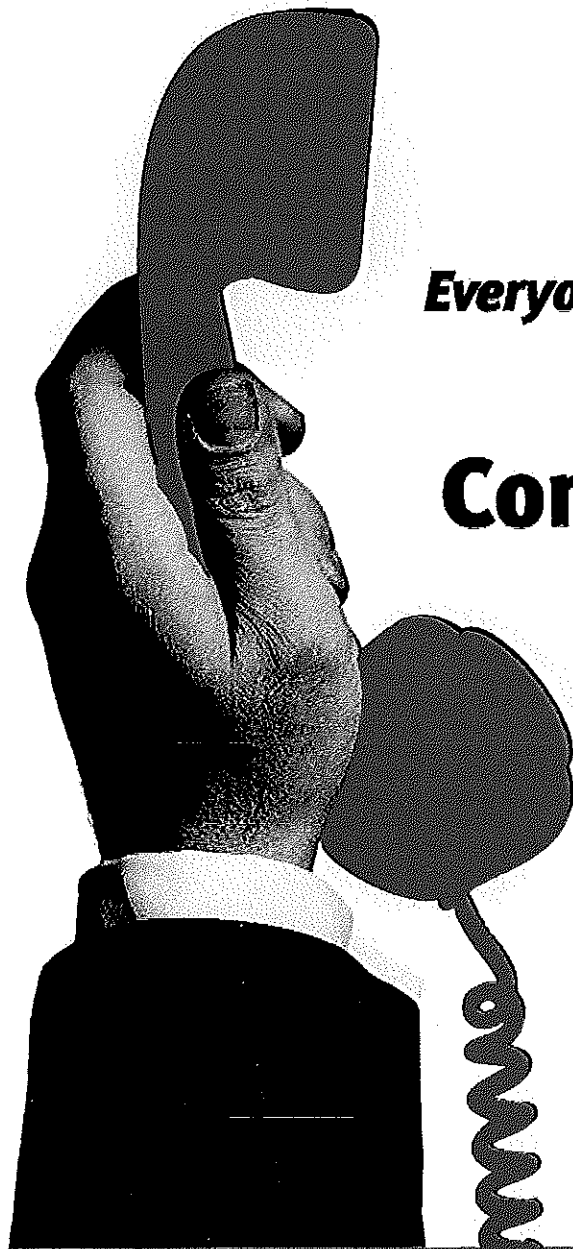
R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.
Revised 5/2003



Louisiana
Workforce
Commission

www.LAWWORKS.net

Is someone you know **cheating** the system?



Everyone pays the price for

Workers' Compensation Fraud

Nationwide Toll-free
Fraud Hotline

1.800.201.3362
(all information remains anonymous)



LOUISIANA WORKS™
DEPARTMENT OF LABOR

www.LAWORKS.net

Office 225.342.7558
Fax 225.342.1880
Email WCFraud@ldol.state.la.us

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