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

OSHA Log Case #

First Report

of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011 Helena, MT 59604-8011

Adjuster Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Female ☐ Unknown	☐ Married ☐ Separated ☐ Widowed, Divorced, Single, Unmarried ☐ Unknown	

Wages

Date Hired	Gross earnings for FOUR pay periods preceding the injury Date/Amount / Date/Amount / Date/Amount / Date/Amount /

Employment Status	Number of days worked per week	Wage	Wage Period
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Piece Worker ☐ Volunteer ☐ Other			☐ Hour ☐ Day ☐ Week ☐ Bi-weekly ☐ Month

In addition to Gross earnings cited above worker received	Estimated value if any	Time Employee began work
☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other		

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury	Salary Continued
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

Accident Description

Job Title	Description of Accident

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury

Date disability began	Date of Death	Names of witnesses
		1) 2) 3)

Accident on employer's premises	Accident address or location		
☐ Yes ☐ No	City	State	Postal Code

Date employer notified	Accident Reported to	Safety equipment provided	Safety Equipment used
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number

Hospital Name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency Room/Urgent Care ☐ Treatment on-site by employer or medical staff ☐ Clinic/Dr. Office ☐ Hospital>24 Hours

Signature

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer or its agent, rehabilitation records, Social Security records and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. I also understand that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft."

Signature of Injured Worker or Beneficiary Date

Employer

Employer Name	Doing Business As	Federal Employer Identification Number (Tax ID)

Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured?
		☐ Yes ☐ No

Employer is a	Injured worker is a
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household

Do you have any reason to question this accident? If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ
☐ Yes ☐ No	☐ Yes ☐ No

Prepared By	Official Title	Phone Number	Date

Payroll Classification Code under which you report employee's wages

Authorized Employer's Signature_____ Date_____

Insurer

Claim Administrator Claim Number	Date reported to Claim Administrator	The above information is correct with the following exceptions ☐ (Attach extra sheets if box at right is checked)

Claim Administrator's Name	Claim Administrator Address	Claim Administrator FEIN

Insurer Name	Insurer FEIN

Policy Number	Policy Effective Date	Policy Expiration Date

OSHA Log Case #

First Report

of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011 Helena, MT 59604-8011

Adjuster Date Stamp

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Home Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Female ☐ Unknown	☐ Married ☐ Separated ☐ Widowed, Divorced, Single, Unmarried ☐ Unknown	

Wages

Date Hired	Gross earnings for FOUR pay periods preceding the injury Date/Amount / Date/Amount / Date/Amount / Date/Amount /

Employment Status	Number of days worked per week	Wage	Wage Period
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Piece Worker ☐ Volunteer ☐ Other			☐ Hour ☐ Day ☐ Week ☐ Bi-weekly ☐ Month

In addition to Gross earnings cited above worker received	Estimated value if any	Time Employee began work
☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other		

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to Work	Full wages paid for date of injury	Salary Continued
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

Accident Description

Job Title	Description of Accident

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date of Injury	Time of Injury

Date disability began	Date of Death	Names of witnesses 1) 2) 3)

Accident on employer's premises	Accident address or location City State Postal Code
☐ Yes ☐ No	

Date employer notified	Accident Reported to	Safety equipment provided	Safety Equipment used
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number

Hospital Name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency room/Urgent Care ☐ Treatment on-site by employer or medical staff ☐ Clinic/Dr. Office ☐ Hospital>24 Hours

Signature

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Signature of Injured Worker or Beneficiary Date

Employer

Employer Name	Doing Business As	Federal Employer Identification Number (Tax ID)

Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured? ☐ Yes ☐ No

Employer is a	Injured worker is a
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ ☐ yes ☐ no

Prepared By	Official Title	Phone Number	Date

Payroll Classification Code under which you report Employee's wages	Authorized Employer's Signature _____ Date _____

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Wages

Date Hired	Gross earnings for FOUR pay periods preceding the injury Date/Amount / Date/Amount / Date/Amount / Date/Amount /

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☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ Yes ☐ No	☐ Yes ☐ No

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Date disability began	Date of Death	Names of witnesses
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Accident on employer's premises	Accident address or location
☐ Yes ☐ No	City State Postal code

Date employer notified	Accident Reported to	Safety equipment provided	Safety Equipment used
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number

Hospital name	Address	State	Postal Code	Phone Number

Type of initial medical treatment received ☐ No Treatment ☐ Emergency room/Urgent Care ☐ Treatment on-site by employer or medical staff ☐ Clinic/Dr. Office ☐ Hospital>24 Hours

Signature

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Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured? ☐ Yes ☐ No

Employer is a	Injured worker is a
☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household

Do you have any reason to question this accident? ☐ Yes ☐ No If yes, please explain fully. Use separate sheet if you need additional space	Was worker injured while in your employ ☐ yes ☐ no

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Insurer Name	Insurer FEIN

Policy Number	Policy Effective Date	Policy Expiration Date

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

(Insert business name and address here.)

Date:

Policy Number:

The above-named employer's workers' compensation insurance coverage is active and in good standing for the period of **to** , provided the employer meets all premium and reporting requirements.

IF YOU ARE INJURED

You should report any on-the-job injury to your supervisor, employer, or insurer as soon as possible. You must report the accident within 30 days. A sole proprietor, partner, manager of a manager-managed limited liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

(Insert insurer name, address and phone number here)

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6532.

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A $50 FINE AGAINST THE EMPLOYER!

ERD800.(Rev 7/2011)