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<sup>®</sup> and Great American Insurance Group<sup>®</sup> are registered service marks of Great American Insurance Company. © 2016 Great American Insurance Company. All rights reserved. 4642-AIL<sup>-1</sup> (6/16)



GreatAmericanCaptive.com

Alternative Markets

#### 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** 



## 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

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<sup>®</sup> and Great American Insurance Group<sup>®</sup> are registered service marks of Great American Insurance Company. © 2016 Great American Insurance Company. All rights reserved. 0826-ALT (2/16)

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

Worker

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LAST NAME				Firs	ST NAME		М	ſ.I.	DATE OF B	RTH		SOCIAL SEC	JRITY NUMBE	2R
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Home Address							C	ITY			Sta	TE	POSTAL COE	θE
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			'ond High Sch		UNKNOWN		WIDOWED, DIVORCED, SINGLE, UNMARRIED							
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EMPLOYMENT STATUS NUMBER OF DAYS WORKED PER WI							WAGE	WAGE	Period	21110/11		/		
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ACCIDENT ON EMP		Ŧ\$	ACCIDENT AD	DRESS OR LOCA										
	No		Сіту		STATE	PC	STAL COI	DE		1				
DATE EMPLOYER N	OTIFIED		ACCIDENT R	EPORTED TO						SAFETY		NT PROVIDED	SAFETY J	Equipment used
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	TYPE OF INITIAL MEDICAL TREATMENT RECEIVED IN O'TREATMENT E EMERGENCY ROOM/URGENT CARE TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF CLINIC/DR. OFFICE													
					S	ignatu	re							
"This is my cla	"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 a	uthorizes the re	lease to	the workers' c	ompensation i	insurer or its agent, re	ehabilitation	records	, Socia	al Security re	cords and	health ca	re information	(medical re	cords, pursuant to
					ection 39-71-604, MC					ned injury.	disease of	or death. <u>I als</u>	o 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														

POLICY EXPIRATION DATE

				Emplo	yer					
Employer name		DOIN	DOING BUSINESS AS					FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID)		
Mailing Address	Сгтү			STATE		Postal Code	Į	PHONE NUMBER		
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS					NATURE OF BUSINESS SIC/NAICS CODE			Self-Insured? 🗌 Yes 🔲 No		
EMPLOYER IS A       SOLE PROPRIETORSHIP       PARTNERSHIP       INJURED WORKER IS A       SOL         CORPORATION       LIMITED LIABILITY COMPANY       A member of the employed in the second s								RATION 🔲 LIMITED LIABILITY COMPANY G 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					0			WAS WORKER INJURED WHILE IN YOUR EMPLOY		
Prepared By		1	Official Title			Phone Number		Date		
PAYROLL CLASSIFICATION CODE UNDER WI REPORT EMPLOYEE'S WAGES				's Signature				Dлте		
	,			Insur	er					
CLAIM ADMINISTRATOR CLAIM NUMBER DATE REPORTED TO CLAIM ADMINISTRATOR						THE ABOVE INFORMA (ATTACH EXTRA SHE		WITH THE FOLLOWING EXCEPTIONS		
CLAIM ADMINISTRATOR'S NAME CL?				IISTRATOR ADDRESS				CLAIM ADMINISTRATOR FEIN		
INSURER NAME						INSURER FEIN	1			

POLICY EFFECTIVE DATE

POLICY NUMBER

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

1	•	•	norona, min	
			Worker	

	Worker												
LAST NAME			FIRST NAM	ΙE			M.I.	DATE OF BII	тн		SOCIAL SECU	URITY NUMBE	ER
HOME ADDRESS			л				Сіту			STA	ΓE	Postal Cod	Е
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IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED ESTIMATED VALUE IF ANY TIME EMPLOYEE BEGAN WORK           ROOM & BOARD         OVERTIME         BONUS         OTHER         TIME EMPLOYEE BEGAN WORK													
					DATE OF RETURN TO WORK FULL WAGES PAL DATE OF INJURY				Y I YES I NO				
Accident Description													
JOB TITLE	DESCRIPTION	n of Accident											
CAUSE OF INJURY		CAUSE CODE PART	OF BODY		PART COI	DE	NATURE OF INJURY NATURE CC			ODE	DE DATE OF INJURY TIME OF INJURY		
DATE DISABILITY B	EGAN	DATE OF DEATH		( <u> </u>	NAME 1)	IMES OF WITNESSES 2) 3)							
ACCIDENT ON EMPI	OYER'S PREMISE NO	S ACCIDENT ADDRESS C CITY	R LOCATION Stat	Е	Po	STAL (	CODE						
DATE EMPLOYER N	OTIFIED	ACCIDENT REPORT	ED TO						SAFETY EQ		NT PROVIDED	SAFETY I	EQUIPMENT USED
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ATTENDING PHYSIC					Pos	STAL C	CODE		PHONE NU	MBER			
HOSPITAL NAME		Address	STATE POSTAL CODE PHONE NUMBER										
	TYPE OF INITIAL MEDICAL TREATMENT RECEIVED D NO TREATMENT E EMERGENCY ROOM/URGENT CARE TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF CLINIC/DR. OFFICE												
"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. <u>I understand</u> that signing this claim for													
compensation a	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. <u>I also understand</u> that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft." <u>Signature of Injured Worker or Beneficiary</u> Date

POLICY EFFECTIVE DATE

POLICY EXPIRATION DATE

			Emplo	yer						
Employer name		DOING BUSINESS AS	i			FEDERAL EMPL	FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID)			
Mailing Address	City	R	STATE		Postal Code	l	PHONE NUMBER			
LOCATION OF OPERATION, IF DIFFERENT FRO	DRESS	J		JRE OF BUSINESS NAICS CODE		SELF-INSURED? YES NO				
EMPLOYER IS A SOLE PROPRIETORSHIP			RSHIP  PARTNERS ROPRIETOR OR PARTNE		RATION LIMITED LIABILITY COMPANY G IN THE EMPLOYER'S HOUSEHOLD					
DO YOU HAVE ANY REASON TO QUESTION THI IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE		I YES ☐ NO CE				WAS WORKER INJURED WHILE IN YOUR EMPLOY				
Prepared By		Official Title	Official Title				Date			
PAYROLL CLASSIFICATION CODE UNDER WHIC REPORT EMPLOYEE'S WAGES							Date			
			Insur	er						
CLAIM ADMINISTRATOR CLAIM NUMBER	TRATOR 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	VISTRATOR ADDRESS				CLAIM ADMINISTRATOR FEIN					
INSURER NAME					INSURER FEIN	1				

ERD ~	991	(Rev.	04/09	ER)

POLICY NUMBER

OSHA Log Case #

#### **First Report**

Adjuster Date Stamp

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

					Worke	er							
LAST NAME			First 1	JAME			M.I.	DATE OF BIR	ATH SOCIAL S		SOCIAL SEC	SECURITY NUMBER	
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HOME ADDRESS							City State					POSTAL COD	E
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					Wages	S							
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DATE DISABILITY BEGAN DATE OF DEA		DATE OF DEAT	Н		NAME:	SOFW	ITNESSES		2)			3)	
			1/							5)			
ACCIDENT ON EMPLOYER'S PREMISES ACCIDENT AND YES NO CITY			ADDRESS OR LOCATION STATE P			DSTAL CODE							
DATE EMPLOYER NOTIFIED ACCIDENT			PORTED TO									EQUIPMENT USED	
			ACCIDENT REFORTED TO									No	

#### Medical

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ATTENDING PHYSICIAN'S NAME	Address	STATE	POSTAL CODE	PHONE NUMBER					
			1 Obiline GODE	THORE HOME AND					
HOSPITAL NAME	Address	STATE	POSTAL CODE	PHONE NUMBER					
			ĺ						
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. Lalso 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	D	OING BUSINESS AS	;			FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID)			
MAILING ADDRESS	City		STATE		POSTAL CODE		Phone Number		
LOCATION OF OPERATION, IF DIFFERENT FROM MA	ILING ADDRESS			SIC/	jre of Business NAICS Code		SELF-INSURED? 🗌 YES 🔲 NO		
Employer is a Sole Proprietorship       Partnership         Injured worker is a Sole Proprietorship       Partnership         Corporation       Limited Liability Company         A member of the employer's (sole proprietor or partners) family living in the employer's household									
DO YOU HAVE ANY REASON TO QUESTION THIS ACC IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHE			∃YES ☐ NO CE				WAS WORKER INJURED WHILE IN YOUR EMPLOY		
Prepared By		Official Title			Phone Number		Date		
PAYROLL CLASSIFICATION CODE UNDER WHICH YC REPORT EMPLOYEE'S WAGES	RIZED EMPLOYER'	's Signature				Dлте			
Insurer									

		ino al ol	
CLAIM ADMINISTRATOR CLAIM NUMBER	DATE REPORTED TO CLAIM ADMINISTRATOR	THE ABOVE INFORMATION IS CORRECT (ATTACH EXTRA SHEETS IF BOX AT RIG	F WITH THE FOLLOWING EXCEPTIONS  GHT IS CHECKED)
CLAIM ADMINISTRATOR'S NAME	CLAIM ADMINISTRATOR A	Address	CLAIM ADMINISTRATOR FEIN
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!