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

Insert insurer name, address, and phone number

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

Date of injury or illness:	Date you left work:	Time you began work on day of injury: ☐ a.m. ☐ p.m.	Regularly scheduled days off: ☐M ☐T ☐W ☐T ☐F ☐S ☐S	DEPT USE:
Time of injury or illness: ☐ a.m. ☐ p.m.	Time you left work: ☐ a.m. ☐ p.m.	Check here if you are employed by more than one employer: ☐		Emp
				Ins
What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐Left ☐Right				Occ
				Nat
What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: fell ten feet when climbing an extension ladder carrying a 40-lb. box of roofing materials)				Part
				Ev
				Src
				2src

Information ABOVE this line; date of death, if death occurred; and OR-OSHA case log number must be released to an authorized worker representative upon request.

Your legal name:		Birthdate:	Gender: M ☐ F ☐
Your mailing address:		Home phone:	
SSN (optional):	Occupation:	Work phone:	
Names of witnesses:			
Name of physician or health-care professional:		If medical treatment was given away from the worksite, print name and address of facility:	
Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
Were you treated in the emergency room? ☐ Yes ☐ No			

By my signature, I am giving notice of a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law require separate authorization.

Worker signature:	Completed by (please print):	Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify your workers' compensation insurance company within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

Employer legal business name:	Phone:	FEIN:
If worker leasing company, list client business name:		Client FEIN:
Address of principal place of business (not P.O. box):		Insurance policy no.:
Street address from which worker is/was supervised: **ZIP:**		Nature of business in which worker is/was supervised:
Address where event occurred:		
Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No		
Were other workers injured? ☐ Yes ☐ No		OSHA 300 log case #:

Date employer knew of claim:	Date worker returned to work:	Worker's weekly wage: $	Date worker hired:	If fatal, date of death:

Employer signature:	Name and title (please print):	Date:

OSHA requirements: On the job fatalities and catastrophes must be reported to OR-OSHA within eight hours. Report any accident that results in overnight hospitalization within 24 hours to OR-OSHA. Call (800) 922-2689, (503) 378-3272, or Oregon Emergency Response (800) 452-0311, on nights and weekends.

Notice to Worker

Important information about your Social Security Number (SSN)

1. You must provide your SSN. The Workers' Compensation Division (WCD) of the Department of Consumer and Business Services (DCBS) has authority to request your SSN under the *Privacy Act of 1974*, 5 USC & 552a (West 1977), Section 7(a)(2)(B). Authority under state law is provided in Oregon Revised Statute 656.265 and under Administrative Order WCB 4-1967 codified at OAR 436 Division 060. DCBS will use your SSN to carry out its duties under ORS Chapter 656, including compliance, research, claims processing, and injured-worker-program administration. The workers' compensation insurer will use your SSN to obtain records related to your claim.
2. DCBS requests your voluntary authorization to give your SSN to other government agencies to use for their statutory duties, including, but not limited to, planning, research, child-support enforcement, employment assistance, benefit coordination, child-labor-law enforcement, risk management, hazard identification, rate setting, and training programs. If you do not authorize this use, please check the box by your signature on the front of Form 801W. Checking this box will not interfere with the processing of your workers' compensation claim.

Caution against making false statements

3. The punishment for anyone who is convicted for knowingly making any false statement or representation for the purpose of obtaining any benefit or payment, is imprisonment for not more than one year, a fine of not more than $1,000, or both, under ORS 656.990(1).

Form 801 is your receipt that you gave notice of a claim. Keep it as your record.

4. Your employer is required to submit your claim to its insurer within five days. The insurer must notify you of its acceptance or denial within 60 days after the date your employer knows of your claim. If your employer is self-insured, the acceptance or denial notice will be sent by your employer or the company your employer has hired to process its workers' compensation claims. If your claim is denied, the reason for the denial and your rights will be explained.

If you have questions about your claim that are not resolved by your employer or insurer, you may contact; (Si Ud. tiene alguna pregunta acerca de su reclamación que no haya sido resuelta por su empleador o compañía aseguradora, puede ponerse en contacto con):

Workers' Compensation Division
(División de Compensación para Trabajadores)
350 Winter Street NE, Rm. 27, Salem, OR 97301-3879
Call Salem: (503) 947-7585, TTY: (503) 947-7993,
or toll-free in Oregon: (800) 452-0288

OR

Ombudsman for Injured Workers
(Ombudsman para Trabajadores Lastimados)
350 Winter Street NE, Salem, OR 97301-3878
(503) 378-3351, TTY: (503) 947-7189,
or toll-free: (800) 927-1271

OREGON DEPARTMENT OF CONSUMER & BUSINESS SERVICES
Workers' Compensation Division

INSTRUCTIONS for Worker's report of occupational injury or disease/illness claim

Worker: Failure to file a claim with your employer within 90 days of injury or within one year of learning you have an occupational illness may result in claim denial. Please read about your rights and responsibilities on the attached "Notice to Worker" and *"Understanding workers' compensation claims."*

Employer: Failure to report a claim to your insurance company within five days after notice or knowledge of the claim may result in untimely payment of time-loss benefits to the worker and a penalty to you or your insurance company. Submit the claim even if the worker is unavailable, unable to provide information, or unable to sign the form.

Completion instructions: Type or print in ink. Write clearly. The numbered items below correspond to those on the 801W and will help you complete the claim form. Form 801W is also available on the Workers' Compensation Division's Web site: **www.oregonwcd.org/pubs/formsbyno.html.**

Worker's report of claim

7. If you were injured, provide the date on which the accident occurred. If you have an occupational illness, enter the date on which you first received medical attention.
10. Describe the type of injury (example: cut leg, broken arm).
11. Enter the number of years of education you have completed (GED is 12.)
12. Identify the body part(s) injured (example: low back, right leg, left shoulder, etc.).
18. Describe the injury or illness as completely as possible.
19. If "Yes," briefly describe the prior injury (example: car accident in 1997, work injury in 1999, etc.).
21. Read this section carefully, as well as **"Important information about your Social Security Number (SSN),"** and **"Caution against making false statements,"** on the attached (or on back) "Notice to Worker."

Employer's section

23. FEIN is the Federal Employer Identification Number, also known as the federal tax identification number.
24. Report the earliest of the following:
    - the date you (any supervisor or manager) first knew of a claim; or
    - the date enough facts existed to lead you to reasonably conclude workers' compensation liability is a possibility.

If you have questions about this form, call the Workers' Compensation Division in Salem, (503) 947-7585, TTY: (503) 947-7993, or toll-free in Oregon: (800) 452-0288.

Si Ud. tiene preguntas relacionadas a este formulario, comuníquese con la División de Compensación para Trabajadores en Salem al número telefónico (503) 947-7585, TTY: (503) 947-7993, o llame gratis en Oregon: 1-800-452-0288.

440-801W (2/02/DCBS/WCD/WEB)

OSHA record-keeping guidelines

If your business is subject to record-keeping regulations, you are required to record information on OSHA Form 300 and maintain records of occupational injuries or illnesses as described below. Every OSHA 300 log entry requires a supporting document. This document may be the federal OSHA Form 301, Oregon Form 801 standard two-page version, or an equivalent. **Even if your business is exempt from record-keeping, you must have a copy of Oregon Form 801 or equivalent at each establishment for each occupational injury or illness that may result in a compensable workers' compensation claim, pursuant to OAR 437-001-0700(14)(a).** Form 801W is not equivalent to the two-page standard Oregon Form 801, but if an employer's incident report or other form collects the following additional information, the forms (together) are equivalent:

From the standard Oregon Form 801, employer's Page 1 of 2: Lines 5, 15, 17, 23, 24, and 38 through 45.
NOTE: The information in Lines 38 through 45 must be maintained in a dedicated section of any form(s) used for OSHA record-keeping without changes.

Federal Form 301 also can be used to supplement the 801W if the worker makes an injury or illness claim.

If a case is recordable under OSHA regulations but is not a claim under workers' compensation laws, complete and retain only the employer page of a standard Oregon Form 801, the federal Form 301, or an equivalent form.

If you are not sure whether your company is subject to OSHA record-keeping requirements or if you have other record-keeping questions, call (503) 947-7030.

An occupational injury or illness is recordable if it is work related and it meets one or more of the following criteria:

1) it results in death
2) there is loss of consciousness
3) there are days away from work, restriction of work or motion, or transfer to another job
4) there is medical treatment beyond first aid
5) a significant injury or illness is diagnosed by a licensed health-care professional

IMPORTANT: The following is a **complete** list of treatments considered by OSHA to be first aid. If the injured worker receives any of these treatments, and **none** of the (five) criteria listed above apply, **the injury is not recordable.**

- Non-prescription medication at non-prescription strength.
- Tetanus immunizations.
- Cleaning, flushing, or soaking of wounds on the surface of the skin.
- Covering wounds with items such as Band-Aids®, gauze pads, butterfly bandages, or Steri-Strips®.
- Heat or cold therapy.
- Non-rigid support, such as elastic bandages, wraps, non-rigid back belts, etc.
- Temporary immobilization during transport as an accident victim.
- Drilling of fingernail or toenail to relieve pressure, or draining fluid from a blister.
- Eye patches.
- Removal of foreign bodies from the eye by irrigation or with a cotton swab.
- Removal of splinters or foreign material from areas of the body other than the eyes by irrigation, tweezers, cotton swab, or other simple means.
- Use of finger guards.
- Massage therapy.
- Drinking fluids for relief of heat stress.

Attention: Report fatalities or catastrophes to DCBS/OR-OSHA within eight hours of occurrence. Call toll-free in Oregon, (800) 922-2689 or (503) 378-3272. Report accidents that result in overnight hospitalization with medical treatment to the DCBS/OR-OSHA local field office within 24 hours of employer notification. At night or on weekends, call Oregon Emergency Response, (800) 452-0311.