

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

Worker

Form section for Worker information including Last Name, First Name, M.I., Date of Birth, Social Security Number, Mailing Address, City, State, Postal Code, Phone Number, Education, Gender, Marital Status, and Number of Dependents.

Wages

Form section for Wages including Date Hired, Gross Earnings for four pay periods preceding the injury, Employment Status, Number of Days Worked per Week, Wage, Wage Period, and other wage-related details.

Accident Description

Form section for Accident Description including 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, and other accident-related details.

Medical

Form section for Medical information including Attending Physician's Name, Address, State, Postal Code, Phone Number, Hospital Name, Address, State, Postal Code, Phone Number, and Type of Initial Medical Treatment Received.

Signature

Signature area containing a disclaimer: "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 (and its agents) and to the Montana Uninsured Employers' Fund of Social Security records; rehabilitation records; and all 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."

Employer

Form section for Employer information including Employer Name, Doing Business As, Federal Employer Identification Number (TAX ID), Mailing Address, City, State, Postal Code, Phone Number, Location of Operation, Nature of Business NAICS Code, Self-Insured status, and other employer details.

Insurer

Form section for Insurer information including Claim Administrator Claim Number, Date Reported to Claim Administrator, Claim Administrator's Name, Claim Administrator Address, Claim Administrator FEIN, Insurer Name, Insurer FEIN, Policy Number, Policy Effective Date, and Policy Expiration Date.

WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

┌ (Insert business name and address here.)

┐ Date:

Policy Number:

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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!