

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 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.



Report Online

To use the app, you will first need to register on the Great American Insured Portal

<https://insuredportal.gaig.com>

- 1. Click the Request Access link**
- 2. Complete the Policyholder Registration form**
- 3. Confirm the Insured Portal system generated "Identity Verification" email**

Preregistration Required



Call our reporting center

877-836-1555



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. © 2020 Great American Insurance Company. All rights reserved. 4642-ALT-1 (5/20)



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.

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

CLAIM REFERENCE					
1. Insured Report Number		2. Filing Office Claim Number		3. OSHA Log Case Number	
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City		8. State	9. Zip		12. City
					13. State
					14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
			23. Mailing Address 2 or Telephone Number		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			24. City		25. State
					26. Zip
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		
36. City			Female <input type="checkbox"/>		42. Nbr of Dependents
37. State			38. Zip		39. Phone
43. Marital Status					44. Date Hired
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work	
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
54. Date Disability Began				55. Date of Death	
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				61. Injury Occurred on Employer's Premises?	
56. Site Address				Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City		58. State		59. Zip	
60. County				62. Date Employer Notified	
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
<p>PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC)</p>					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	
73. Name of Physician or Other Health Care Professional				74. Has Injured Returned to Work	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				If so, 75. Date	
				76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
OTHER					
77. Date Prepared		78. Preparer's First Name		79. Last Name	
				80. Title	
81. Preparer's Telephone Number					

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

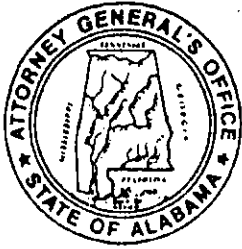
CLAIM REFERENCE					
1. Insured Report Number		2. Filing Office Claim Number		3. OSHA Log Case Number	
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City		8. State	9. Zip		
15. Federal ID Number			16. U.C. Account Number		17. NAICS
12. City			13. State		14. Zip
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			23. Mailing Address 2 or Telephone Number		
			24. City		25. State
			26. Zip		
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		42. Nbr of Dependents
36. City			Female <input type="checkbox"/>		
37. State			38. Zip		39. Phone
43. Marital Status					44. Date Hired
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work	
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
54. Date Disability Began				55. Date of Death	
PLACE OF ACCIDENT, INJURY, OR EXPOSURE				61. Injury Occurred on Employer's Premises?	
56. Site Address				Yes <input type="checkbox"/> No <input type="checkbox"/>	
57. City		58. State		59. Zip	
60. County				62. Date Employer Notified	
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
<p>PROVIDE DESCRIPTION CODES to identify Nature of Injury, Part of Body that was affected, and Cause of Injury. (FOR COMPLETE LIST OF CODES, GO TO HTTP:// LABOR.ALABAMA.GOV/WC)</p>					
64. Nature of Injury Code		65. Part of Body Code		66. Cause of Injury Code	
67. Initial Treatment		No Medical Treatment <input type="checkbox"/>		68. Name of Treatment Facility	
First Aid By Employer <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		69. Address	
Emergency Room <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		70. City	
Hospitalized > 24 Hours <input type="checkbox"/>		Outpatient Treatment <input type="checkbox"/>		71. State	
73. Name of Physician or Other Health Care Professional				74. Has Injured Returned to Work	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				If so, 75. Date	
				76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
OTHER					
77. Date Prepared		78. Preparer's First Name		79. Last Name	
				80. Title	
				81. Preparer's Telephone Number	

STATE OF ALABAMA
EMPLOYER'S FIRST REPORT OF INJURY
OR OCCUPATIONAL DISEASE

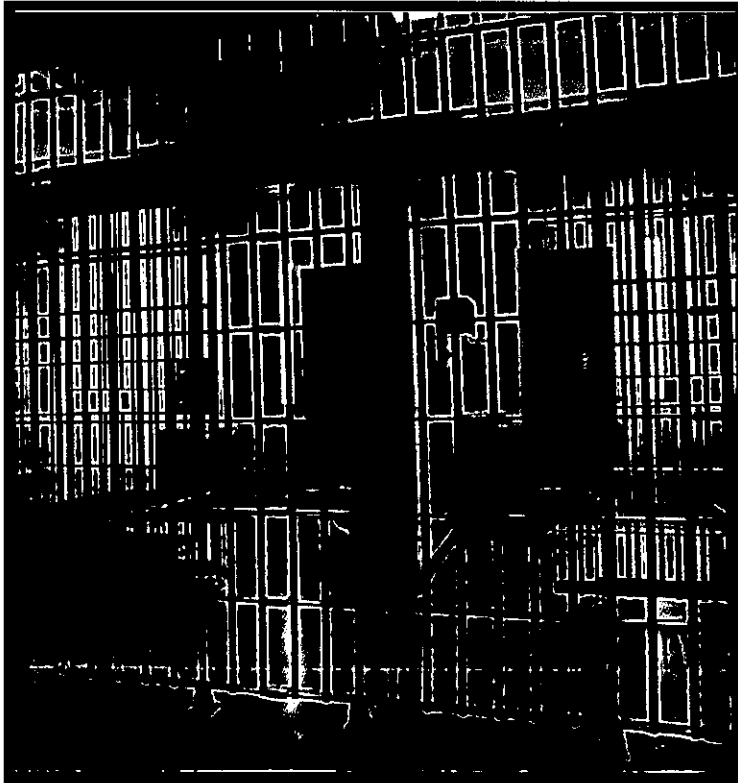
CLAIM REFERENCE					
1. Insured Report Number		2. Filing Office Claim Number		3. OSHA Log Case Number	
EMPLOYER					
4. Employer Business Name			ADDRESS, IF LOCATION DIFFERENT FROM BUSINESS ADDRESS		
5. Physical Address 1			10. Mailing Address 1		
6. Physical Address 2			11. Mailing Address 2		
7. City		8. State	9. Zip		12. City
					13. State
					14. Zip
15. Federal ID Number		16. U.C. Account Number		17. NAICS	
INSURER / FILING OFFICE					
18. Insurer Name			21. Filing Office Name		
19. Insurer Federal ID Number			22. Mailing Address 1		
			23. Mailing Address 2 or Telephone Number		
20. Type Insurer Ins Co <input type="checkbox"/> Self-Insurer <input type="checkbox"/> Group Fund <input type="checkbox"/>			24. City		25. State
					26. Zip
			27. Filing Office Federal ID Number		
EMPLOYEE / WAGES					
28. First Name			32. Employee ID Number		
29. Middle Name			33. Type Employee ID Number		
30. Last Name			SSN <input type="checkbox"/> Passport Number <input type="checkbox"/> Green Card <input type="checkbox"/>		
31. Last Name Suffix (ie. Jr., Sr., III)			Employment Visa <input type="checkbox"/> Assigned by Jurisdiction <input type="checkbox"/>		
34. Mailing Address 1			40. Gender		41. Date of Birth
35. Mailing Address 2			Male <input type="checkbox"/>		
36. City			Female <input type="checkbox"/>		42. Nbr of Dependents
37. State			38. Zip		39. Phone
43. Marital Status			44. Date Hired		
Unmarried (Single or Divorced or Widowed) <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unknown <input type="checkbox"/>					
45. Occupation Description				46. Number of Days Worked Per Week	
47. Wages \$			49. Received Full Pay For Day of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/>		
48. Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/>			50. Did Salary Continue? Yes <input type="checkbox"/> No <input type="checkbox"/>		
INJURY / TREATMENT					
51. Date of Injury		52. Time of Injury		53. Time Employee Began Work	54. Date Disability Began
		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unk <input type="checkbox"/>		a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
55. Date of Death			PLACE OF ACCIDENT, INJURY, OR EXPOSURE		
56. Site Address			61. Injury Occurred on Employer's Premises?		
57. City			Yes <input type="checkbox"/> No <input type="checkbox"/>		
58. State			62. Date Employer Notified		
59. Zip					
63. DESCRIBE WHAT THE EMPLOYEE WAS DOING JUST BEFORE THE INCIDENT AND HOW THE INJURY OCCURRED. (Ex. While climbing a ladder and carrying roofing materials, ladder slipped on wet floor causing worker to fall 20 feet.)					
64. Nature of Injury Code					
65. Part of Body Code		66. Cause of Injury Code			
67. Initial Treatment		68. Name of Treatment Facility		69. Address	
First Aid By Employer <input type="checkbox"/>		No Medical Treatment <input type="checkbox"/>		70. City	
Emergency Room <input type="checkbox"/>		Minor Clinic / Hospital <input type="checkbox"/>		71. State	
Hospitalized > 24 Hours <input type="checkbox"/>		Hospitalized Overnight <input type="checkbox"/>		72. Zip	
Outpatient Treatment <input type="checkbox"/>		73. Name of Physician or Other Health Care Professional		74. Has Injured Returned to Work	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
				If so, 75. Date	
				76. Time a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	
OTHER					
77. Date Prepared		78. Preparer's First Name		79. Last Name	
				80. Title	
				81. Preparer's Telephone Number	

WORKERS' COMPENSATION FRAUD

It could be a ticket to jail!



The Alabama
Attorney
General's
Office and the
Alabama
Department of
Industrial
Relations



are working
together to
find and
prosecute
Workers'
Compensation
Fraud.

Workers' Compensation Fraud is STEALING!

W A N T E D

INFORMATION LEADING TO THE DISCOVERY AND OR CONVICTION OF WORKERS' COMPENSATION FRAUD.

Making a false statement to obtain workers' compensation benefits (Ala. Criminal Code, Section 13A-11-124) is a Class C Felony under Alabama law. Class C Felonies are punishable by imprisonment for as much as 10 years and monetary fines of up to \$15,000.

FIVE TYPES OF WORKERS' COMPENSATION FRAUD

Agent ~ Employer ~ Employee ~ Medical ~ Legal

WORKERS' COMPENSATION FRAUD CAN BE:

- * Reporting an off the job accident as an on the job accident.
- * Reporting an accident that never happened.
- * Complaints of accident injury symptoms that are exaggerated or non-existent.
- * Malingering - to avoid work when injury is healed.
- * Not reporting outside income from other work-related activities while drawing workers' compensation benefits from another employer.
- * Making false or fraudulent statements for the purpose of obtaining workers' compensation benefits.

**TO REPORT WORKERS' COMPENSATION FRAUD
CALL**

1-800-923-2533 or 334-242-7345

Establishing a Managed Care Panel

Great American Insurance Group has contracted with Procura/Optum to provide customizable Physician and Clinic Networks for our insureds. These networks provide injured workers with industry leading care and medical treatment at significant cost savings to employers.

Most states have specific guidelines governing the right for an employer or employee to direct care in the event of an industrial injury. Some states require the establishment of a Medical Panel for the initial treatment of work-related injuries. Due to the significant cost savings associated with Medical Panels, Great American – Alternative Markets recommends that employers establish medical Panels for all work locations.

Mandatory Panel States: GA, PA, TN, VA

Medical Provider Network (Opt-in): California

Medical Panels will need to be established BEFORE you have your first claim. Please fill out the below questionnaire listing all work locations and send to:

AlternativeMarketsAccountServices@GAIG.COM

Once received, you will be contacted by a member of our account services team to discuss the needs of your business and how to best construct the medical panel that will deliver appropriate coverage to your employee population.

Questionnaire

Named Insured: _____

Location: _____

Address: _____

Contact name: _____

Contact phone number: _____

Employee count: _____

Current network: Yes No