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

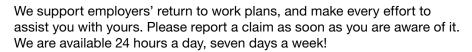
Preregistration Required



Call our reporting center



877-836-1555



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. 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.

AVISO

SI SE LASTIMA EN EL TRABAJO, DEBE DARLE UN AVISO POR ESCRITO A SU EMPLEADOR DENTRO DE CUATRO DÍAS LABORABLES DEL ACCIDENTE, SEGÚN A LA SECCIÓN DE LOS ESTATUOS REVISADOS DE COLORADO 8-43-102(1) Y (1.5).

SI EL ACCIDENTE RESULTA
DEBIDO AL USO DE ALCOHOL O
UNA SUSTANCIA CONTROLADA,
SUS BENEFICIOS DE LA
INCAPACIDAD DE LA
COMPENSACIÓN DE LOS
TRABAJADORES PUEDEN SER
REDUCIDOS POR UN MEDIO EN
ACUERDO DE LA SECCIÓN DE
LOS ESTATUOS REVISADOS DE
COLORADO 8-42-112.5.

·				

WARNING

IF YOU ARE INJURED ON THE JOB, WRITTEN NOTICE OF YOUR INJURY MUST BE GIVEN TO YOUR

EMPLOYER WITHIN FOUR WORK-ING DAYS AFTER THE ACCIDENT, PURSUANT TO SECTION 8-43-102 (1) AND (1.5), COLORADO REVISED STATUTES.

IF THE INJURY RESULTS FROM YOUR USE OF ALCOHOL OR CONTROLLED SUBSTANCES, YOUR WORKERS' COMPENSATION

DISABILITY BENEFITS MAY BE REDUCED BY ONE-HALF IN ACCORDANCE WITH SECTION 8-42-112.5, COLORADO REVISED STATUTES.

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	

Great American Insurance Group, 301 E Fourth Street, Cincinnti, OH 45202. This is not intended as legal advice; if you have any questions or issues of a specific nature, you should consult appropriate legal or regulatory counsel to review the specific circumstances involved. 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. 1251-ALT-CA (06/20)



Instructions for Completing the

First Report of Injury

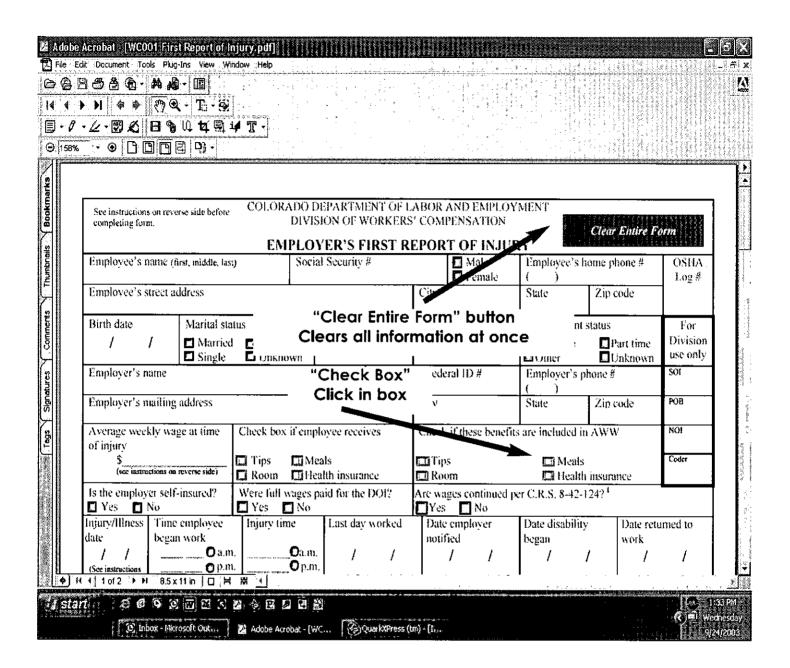
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will <u>not</u> be able to save the form onto your computer's hard drive.

When you open the form, click in the "Employee's Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the <u>Enter</u> key; pressing the <u>Enter</u> key will only page down. Each field has been *limited*. This means that you <u>cannot</u> continue to type information into a field if it doesn't fit into the space provided.

Use numbers <u>only</u> to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, <u>do</u> type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.



□ File	e Acrobat - [WCOO1 First Report of Edit Document Tools Plug-Ins View V					5 ×
Ð∙۵	> N		Check Boxes v Check	with one sele conly one	ction"	
Bookmarks	Average weekly wage at time of injury \$ (see instructions on reverse side) Is the employer self-insured?	Check box if employee receives Tips	Check if these tenefits Fips Room Are wages continued p	Meals Health insura	Coder	11
s \ Thumbrialis		Injury time Last day worked ay Border" n and tab to next field	Pes No Date employer notified / /	Date disability began	Date returned to work	
res Connent	Did injury cause H so, date of de Yes No	Name, relationship, and address	of closest dependent if in	O into	v occurred because of exication ety violation tapplicable	The second secon
Tegs Signet	Tell us the part of body that wa What was the employee doing j	s affected ust befue the accident occurred?	fell us the nature of the in	niurv/illness ²		on and the state of the state o
	Tell us how the injury occurred		What object or substance			
•	on premises?	ddress/ 9-digit zip code Initial treatmen	Emergency roo	Was the employed overnight as an in	-patient?	•
74 SI		M 令 国 日 配 M Adobe Acrobet - (WC G QuarkSPress	(tm) - [1 🛅 Document 1	Microsof	(II- 1136 PI 《 河 Nedness 9/24/20	day

See instructions on rev completing form.	erse side befo	JIC					AND EMPLO' ENSATION	YMENT			
		EMPL	OYER'S	S FIRST	RE	EPORT	Γ OF INJU	RY			
Employee's name (first, middle,		ocial Secu				☐ Male ☐ Female	Employee's	s home pl	none #	OSHA Log #
Employee's street a	iddress					City		State	Zip o	ode	
Birth date	Marital	status	Date o	f hire		Occupa	ation	Employme	nt status		For
/ /	☐ Marr ☐ Singl	— ,	/				☐ Full time☐ Other		Part time Unknown		
Employer's name		Empl	oyer	yer's Federal ID # Employer's phone #					SOI		
Employer's mailing	g address			•		Citv		State	Zip c	ode	POB
Average weekly wa	ige at time	Check box if e	mployee re	eceives		Check	if these benefi	its are included	l in AWW	,	NOI
\$(see instructions of	n reverse side)	_ ,	Meals Health ins	urance		☐ Tips		☐ Mea	als Ith insura	nce	Coder
Is the employer self	f-insured?	Were full wage	es paid for			Are wag	es continued	per C.R.S. 8-42			
	e employe	Yes N E Injury time		day worke		Date	No employer	Date disabi	lity	Date retu	ımed to
date bega	n work O		ı.m.	, ,		notifi	ed / /	began /	1	work /	1
(See instructions on reverse side)	O	o.m. O unknown	o.m.	, ,			,	'	,	,	,
Did injury cause death?	If so,		lationship.	and addre	ess of	f closest	dependent if	injury caused		occurred xication	because of
Yes No	duic or	death death and a second							O Safe	ty violatio	
Tell us the part of b	ody that w	/as affected		00000000000000000000000000000000000000	Те	ll us the	nature of the	injury/illness²		applicable	

What was the empl	oyee doing	g just before the acc	ident occu	irred?	MICCOLOGICAL COMM	325:26:2 7:22:20:06:01:20:00	green electron september de companya participa participa de constituente de constituente de constituente de co			alitatoliasiaskasiastastastastas	KONTONIA ORANIA MARIANTA MARIA
Tell us how the inju	iry occurre	ed*[Ľ	hat obje	ect or substance	ce directly harr	ned the er	nployee?	
Did injury occur on premises?	Injury site	address/ 9-digit zip	code In	itial treatn	nent	(check on	e)		employee	hospitali:	zed
Yes No				None			Emergency ro		∏No	-patient:	
				Minor on Clinic/ho			Hospital >24 h				
Names of witnesses	WWW.			Wed means and a second	. î		employer repr	I esentative noti	fied	· · · · · · · · · · · · · · · · · · ·	
Name and address of	of treating	doctor or other hea	lth care pr	ofessional	N	ame and	address of fa	cility where tre	eated		
Completed by (nam	ie)	-	Γitle				Phone #	#*************************************	Date	completed	<u></u> d
		to be completed b	y the insu	rer prior			h the Division	n of Workers'	Compen	sation.	
Name of insurance	company				A	ddress					
Name of third party	administr	ator (if applicable)			A	ddress	×				
Adjuster name		· · · · · · · · · · · · · · · · · · ·			A	djuster p	hone #				
Policy #		Carrier claim #			Da	ate insur	er received fin	rst report	Block	# A	dj. Code

INSTRUCTIONS

This form contains all items requested on OSHA Form No. 301, "Injuries & Illnesses Incident Report"

General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer if the employer will not be paying such benefit during the period of disability.
- If the employee is covered by group health insurance and the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the Average weekly wage at time of injury field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?¹

(Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness²; What was the employee doing just before the accident occurred?³; What happened?⁴; What object or substance directly harmed the employee?⁵)

- 2 Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 3 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
- 4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

Notices

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

Instructions for Completing the

First Report of Injury

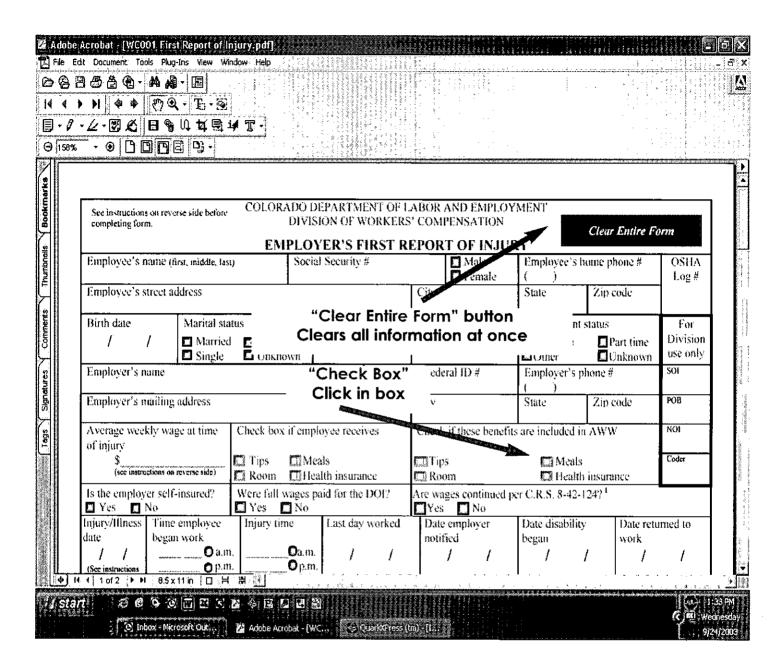
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will <u>not</u> be able to save the form onto your computer's hard drive.

When you open the form, click in the "Employee's Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the <u>Enter</u> key; pressing the <u>Enter</u> key will only page down. Each field has been *limited*. This means that you <u>cannot</u> continue to type information into a field if it doesn't fit into the space provided.

Use numbers <u>only</u> to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, <u>do</u> type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.



Check Boxes with one selection Check box if employee receives Check if these tenefits are included in AWW NOI Coder		Acrobat - [WC001 Fire											[8]X
Check Boxes with one selection Check only one Coder Co	2 14 15 15 15 15 15 15 15 15 15 15			ndow Help			1.0		11.11.19.27.37	2.45.23.0		\$ 21.2 Li	Carrier and the state of the second
Check Boxes with one selection	12.53.23.34,53323	· · · · · · · · · · · · · · · · · · ·	1417 143 P. P. P. J. S.										/Al adobe
Average weekly wage at time of injury Average weekly wage at time of injury	772277	1		₩ Ф _		•	'Check	Boxes	with one	sele	ction"	3078 ARR, 338	
Average weekly wage at time of injury Tips	\$110.00 NOR NOR NORTH			7 8				Chec	k only or	ie			
of injury Sign Sig	ИП			Check box	if employe	e receives	Check if	these Lenefi	ts are included	in AWW	,	NOI	I D
Enter information and tab to next field Did injury cause death? If so, date of death	ırks		•		, ,				and the second			6 ¹ -4	
Enter information and tab to next field Did injury cause death? If so, date of death	okm	(see isstructions on	reverse side)			insurance		4	20202		nce	(.0027	
Enter information and tab to next field Did injury cause death? If so, date of death	S Bo		insured?	Were full	wages paid		Are wage	s continued					
Enter information and tab to next field Did injury cause death? If so, date of death	umbnall		n work	Injury tir	ne L	ast day worked	Date er	nployer		ty		rned to	
Yes No Safety violation Shot applicable Tell us the part of body that was affected What was the employee doing just before the accident occurred? Tell us how the injury occurred What object or substance directly harmed the employee?	Ç.	: Fmlowinto		•			/	1	1	1	/	1	
Yes No Safety violation Not applicable Tell us the part of body that was affected Tell us the nature of the injury/illness What was the employee doing just before the accident occurred? Tell us how the injury occurred What object or substance directly harmed the employee?	rents			-						- L .			
Yes No Description Onto applicable Tell us the part of body that was affected Tell us the nature of the injury/illness What was the employee doing just before the accident occurred? Tell us how the injury occurred What object or substance directly harmed the employee?	Com					inp, and addres	s of closest d	ependent il i	mjury caused			because of	
What was the employee doing just before the accident occurred? Tell us how the injury occurred! What object or substance directly harmed the employee?		Yes No								∭ ⊃ Safe	ety violatio		
What was the employee doing just before the accident occurred? Tell us how the injury occurred! What object or substance directly harmed the employee?	nature	Tell us the part of b	/_/ ody that was	affed ed	************************		Tell us the n	ature of the	iniury/illness ²	UNG	аррисави		-
Tell us how the injury occurred What object or substance directly harmed the employee?	Sig					1/3							
Tell us how the injury occurred What object or substance directly harmed the employee?	Tags	what was the empte	ovec doing ji	isi derge inc	accideni ()	ccurred? [**************************************				***************************************	
	Ы	Tell us how the into	ov occurred ⁴	N .			What objec	or substanc	o directly barn	ed the e	malayse ^{9 5}		

Did injury occur Injury site address/9-digit zip code Initial treatment (check one) Was the employee hospitalized overnight as an in-patient?			Injury site ad	dress/9-digi	t zip code	Initial treatme	ml (check one)					ed	
Yes No None Emergency room Yes No		<u> </u>				T None	™ 67	neroency roc	'		-pasient		
S His 1012 PM 85X416 DIR WOLLD IN EACH DEATH OF THE STATE	 	1 of 2 ▶ № 8.5×	(11 in 🗍 🛱		TALL					117 السنة القالية	BR41.B		! 별
Ustart ことりの面目では今日 P B B B B B B B B B B B B B B B B B B						100			i i constanti			200	
😯 🖺 Wednesday Di Inbox - Microsoft Out 🚜 Adobe Acrobet - [WC 💪 Cuark XPress (tm) - [I 🗓 Document I. Microsof						: Ouari C Fres	etin II	■ Document i	Microsof				

See instructions on reve completing form.	erse side befor	D	IVISI	ON OF W	VORKERS	G' COM	IPENSA	TION				
F12					IRST R	EPOF				1		CCLIA
Employee's name (irst, middle, la	ast)	Social	Security	#		☐ Ma		Employee's	home pi	ione #	OSHA Log #
Employee's street a	ddress				City	<u> </u>	marc	State	Zip c	ode		
Birth date	Marital s	tatus	1	Date of hi	re	Occu	pation		Employmen	ıt status		For
/ /	■ Marrie ■ Single		1	/		-		☐ Full time ☐ Part time ☐ Other ☐ Unknown			Division use only	
Employer's name	1 5				Employe	r's Fed	eral ID #	#	Employer's	phone #		SOI
Employer's mailing	address					Citv			State	Zip c	ode	POB
Average weekly wa of injury	ge at time	Check box if	emplo	yee recei	ves	Chec	k if these	e benefits	are included	in AWW	/	NOI
\$		-	Mea			Ti			☐ Mea	- -		Coder
(see instructions on	reverse side)	-		th insura		I Ro				th insura	nce	
Is the employer self Yes No		Were full way				Ye	s 🔲 N	No	er C.R.S. 8-42			
	e employee n work	Injury time		Last day	worked		e emplog ified	yer	Date disabili began	ity	Date retu work	irned to
/ / _	Oa.		a.m.	1	/		/	1	/	1	/	/
(See instructions on reverse side)	O p.	.m. O unknowr	p.m.									
Did injury cause	If so,			nship, and	d address o	of close	st depen	dent if in	jury caused	Injury	occurred	because of
death?	date of d	eath death		***************************************						-	xication	
Yes No	! ,					***************************************	######################################			V	ety violation	
70 11 .4	/	<u>/ </u>	do man en adado do	zando sidadores en escribirarios				C.1	. 251 2	UNO	applicable	e
Tell us the part of b	ody that wa	as affected	······		<u> </u>	ell us t	ne nature	e of the ir	ijury/illness ²	······································	······································	······································
What was the emplo	oyee doing	just before the ac	cciden	t occurred	d? ³							**************************************
						CONTRACTOR CONTRACTOR			elis elisabilitationale altri instrument estat instrument estat estat estat estat estat estat estat estat esta			
Tell us how the inju		141			1	1/hat al	ingt on a	whatanaa	directly harm	and the ex		5
Ten us now me inju	ry occurred	1 [***************************************			w nat of	oject or s	substance	directly narm	ied the ei	mpioyee?	od aces control aces conservation aces of contributions
		11 /0 /	la internaciona					William of the state of the sta		•		•
Did injury occur on premises?	injury site a	iddress/ 9-digit z	ıp coa	le Inilia	l treatmen	l (check	one)		overnight		hospitali: -patient?	zed
Yes □ No					ne.	Г] Emerge	ency rooi	-	No	•	
1103				— 🔲 Мі	inor on-site inic/hospit	e [al >24 hr				
Names of witnesses				1			f employ	er repres	entative notif	ied	V-0	
Name and address of	of treating d	loctor or other he	alth c	are profes	ssional , 1	Name a	nd addre	ss of faci	lity where tre	ated		
C111- (T'41.			~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	I DI	11	······································	T D .		1
Completed by (name) Title Phone # () Date completed / / /							a /					
The fo	llowing is	to be completed	by th	e insurer	prior to	filing w	ith the l	Division	of Workers'	Comper	sation.	
Name of insurance			J			Address						
Name of third party		tor (if applicable	<u>:)</u>		F	Address						
Adjuster name						Adinste	r phone #	#				
	10	Carrier claim #							1 ranort	D10.01.	44 44	di Codo
Policy #	10	arrier claim #			'	vale ins	игег ге се /	eived firs /	ı report	Block	# A	.dj. Code

INSTRUCTIONS

This form contains all items requested on OSHA Form No. 301, "Injuries & Illnesses Incident Report"

General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer if the employer will not be paying such benefit during the period of disability.
- If the employee is covered by group health insurance *and* the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the Average weekly wage at time of injury field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?¹ (Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness²; What was the employee doing just before the accident occurred?³; What happened?⁴; What object or substance directly harmed the employee?⁵)

- 2 Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
- 4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

Notices

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

Instructions for Completing the

First Report of Injury

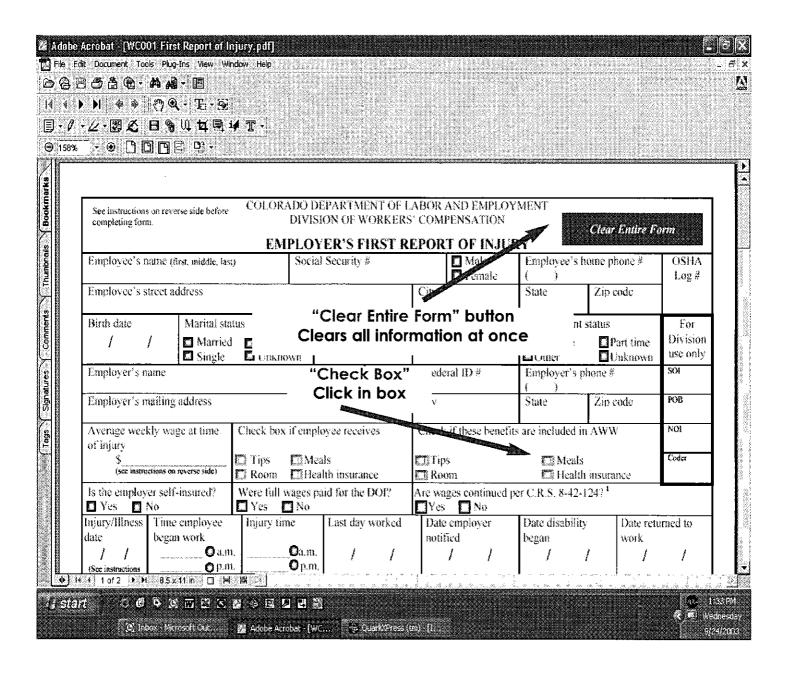
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will <u>not</u> be able to save the form onto your computer's hard drive.

When you open the form, click in the "Employee's Name" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the <u>Enter</u> key; pressing the <u>Enter</u> key will only page down. Each field has been *limited*. This means that you <u>cannot</u> continue to type information into a field if it doesn't fit into the space provided.

Use numbers <u>only</u> to fill in the fields for Social Security #, phone numbers and dollar amounts. If a dollar amount contains cents, <u>do</u> type the period. To fill in a check box, click inside the box with your mouse. Some check boxes require you to select only one answer; you cannot check both. The "Injury Description", "Name of Witness", and "Name of Doctor" fields have a gray border to indicate how many lines you have to type in. Use the tab key to navigate to the next field.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To change the information in one field, use the backspace or delete key.



	e Acrobat - [WC001 Fir					12.200 1 2 2 2 2 1	··::::::::::::::::::::::::::::::::::::					. [a][X]
20 0 0 0 0 0 0 0	Edit Document Tools Plu		ndow Help									_ 5 X
08	3529·44											74
14 4	▶ ▶ 🍇 🍇 ੴ	Q + T ₀ + 52		-		'Check Bo	ovec wi	th one	مادة	ction"	gar in angun pagan É	
■•0	· 🗸 - 📆 🗷 🖯 🤋	的体柱量	4 T -		:		Check of			CHOH		
9 158%		E) D; •			- Marcon		. 	Jilly Oi			-2002-40-2	To work the state of the state
	Average weekly wa	age at time	Check bo	x if employs	ee receives	Check if the	se l'enefits a	re included	in AWW	ŗ	NOI	Ŀ
nark:	of injury \$		□ Tips	Meals		Tips	/	☐ Mea	ls		Coder	1 6
30km	(see instructions o	a reverse side)		Health	insurance	Room	<i>-</i>		lth insura	nce		
Thumbhalls Bookmarks	Is the employer sel Yes No	f-insured?	Were full ☐ Yes		for the DOI?	Are wages co		C.R.S. 8-4:	2-124? 1			
landi	Injury/Hiness Tim		Injury to	ine L	ast day worked			Date disabil	ity	Date retu	med to	
T-	date bega	m work	l Iy Bord	lor"		notified	, b	egan ,	,	work,	,	
Ы	Enter info		-		ovt field		′	/	1	/	1	
rents	L'		•						h ·			
Comments	Did injury cause death?	If 50, date of de			nip, and addres	s of closest deper	ndent if inju	ry caused		occurred b xication	because of	N. N. A.
	Yes No			2						ety violatio	181	:
inres			/		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~					applicable	}	
Signetures	Tell us the part of b	oody that was	affected			Tell us the natur	re of the inju	ry/illness2				
\mathbb{H}	What was the empl	lovee doing ji	ist befo e tl	ne accident (ecuned? ³			***************************************	***************************************	•		
Tags							***********					
	Tell us how the inf	ary accurred				What object or	substance d	icectly hard	ned the er	mnlavee? 5		
			1									
						***************************************	***************************************					85.05 0
	Did injury occur	njary site ac	dress/ 9-dip	git zip code	Initial treatme	mt (check one)	······································	Was the	employee	hospitaliz	ed	1
	on premises?					,		overnigh	t as an in	-patient?		
	Yes No				None		gency room		No			
•	₭ € 1 of 2 ୬ ዝ 85							1111	3 3 6			
l Sis	it cos	o w ≥ o	Z A E	로 및 왕					HIII	11/11/11/11	232 (m)	1:36 PM
	© Ignoc M	arcedi Out	🐉 Athhe A	crohat - IWC	6 Ouark/Pres	: (๒) : [L 🗓	Document : - Mir	rosof.	1111111	: 4 2 3 2 8 1 4 5 5.	(),Ē,	ednesday
				100			*********		2.1	وفقروفندي		12412335

See instructions on revo	erse side before	DI	O DEPARTM VISION OF	WORKERS	S' COMI	PENSATION	N				
Employee's name (f	irst, middle, las		OYER'S I		EPOR	Male Female		oyee's h	ome ph	one #	OSHA Log#
Employee's street a	ddress				City		State	<u>, </u>	Zip code		
Birth date / /	Marital sta Married Single			nire /	Occup	ation	Ful	Employment status Full time Other Unknown			For Division use only
Employer's name	, 5			Employe	r's Fede	ral ID#	Empl	oyer's p			SOI
Employer's mailing	address				Citv		State	,	Zip co	ode	POB
Average weekly wa of injury \$	ge at time	Check box if o	employee rece	eives	Check	if these ben		luded in	AWW		NOI Coder
(see instructions on		I□ Room □	Health insur		□ Roc	m		l Health		nce	
Is the employer self Yes No	-insured?	Were full wag		e DOI?	Are wa	ges continue No	ed per C.R.S	S. 8-42-1	124?		
	employee n work	Injury time	Last da	y worked	Date notif	employer ied	Date of began	lisability	′	Date retu work	rned to
(See instructions on reverse side)	Oa.n Op.n	I ————	a.m. / p.m. /	/		/ /		,	/	/	1
Did injury cause death? Yes No	If so, date of dea	Name, re	elationship, ai	nd address	of closes	t dependent	if injury ca	used	Olnto OSafe	occurred lication ty violation	
Tell us the part of b	ody that was	affected	**************************************	T	ell us the	e nature of th	he injury/ill	ness ²			·
What was the emplo	yee doing ju	ust before the ac	cident occurre	ed? ³ [· · · · · · · · · · · · · · · · · · ·	All the state of t		********		PEO-05-07-07-07-07-07-07-07-07-07-07-07-07-07-	.000,000,000,000,000,000,000,000,000,00
											May be region for a Strong way Strong with the right
Tell us how the inju	ry occurred	1			What obj	ect or substa	ance directly	y harme	d the en	nployee?	
on premises?	njury site ad	ldress/ 9-digit zi		al treatmen	_		ove	ernight a	s an in-	hospitaliz patient?	:ed
Yes No			——	lone Linor on-sit Linic/hospit	e 🔲	Emergency Hospital >2	4 hrs]No		
Names of witnesses		***********************************	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	1	Name of	employer re	presentativo	e notifie	d		
Name and address o	f treating do	ctor or other he	alth care profe	essional 1	Name an	d address of	facility wh	ere treat	ed	***************************************	
Completed by (nam	e)		Title			Phone #		a maa maa maa ma'a nii mii mii may maga m	Date	completed	l /
		be completed	by the insure	er prior to	filing wi	th the Divis	ion of Wor	kers' C	ompen	sation.	
Name of insurance of	company			Ā	Address						
Name of third party	administrato	or (if applicable)	1	A	Address						
Adjuster name				A	Adjuster phone #						
Policy #	Ca	ırrier claim #		Ţ.	Date insu	rer received	first report		Block	# A	dj. Code

INSTRUCTIONS

This form contains all items requested on OSHA Form No. 301, "Injuries & Illnesses Incident Report"

General

- All injuries no matter how trivial must be reported to your insurance company.
- All injuries or occupational diseases which result in lost time from work in excess of three shifts or calendar days, or in permanent physical impairment, must be reported to your insurance carrier on this form within ten days after notice or knowledge of the injury or disease. Fatalities must be reported to your insurance carrier immediately.
- Forms should be typed or printed legibly.
- All questions must be answered completely to meet requirements of the Colorado Workers' Compensation Act and to conform to the OSHA requirements for Form No. 301.
- The employer has the right in the first instance, to select the physician who attends the injured employee.

Calculation of Average Weekly Wage

- Determine the weekly wage rate.
- Add the average weekly amount of any overtime wages, tips or commissions.
- Add the average weekly value of any board, rent, housing, or lodging provided by the employer if the employer will not be paying such benefit during the period of disability.
- If the employee is covered by group health insurance and the employer does not continue the employee's health insurance coverage during the period of disability, add the employee's cost of conversion to a similar or lesser insurance plan and include this cost in the average weekly wage computation.
- Compute the total from the above categories and insert in the Average weekly wage at time of injury field.

Injury Date Information

In the case of an occupational disease, use the date of the last injurious exposure.

Notes

Are Wages continued per C.R.S. 8-42-124?¹ (Subject to application with and approval of the Director of the Colorado Division of Workers' Compensation)

Any employer who, by separate agreement, working agreement, contract of hire, or any other procedure, continues to pay a sum in excess of the temporary total disability benefits to an employee temporarily disabled as a result of a work related injury or disease, and has not charged the employee with any earned vacation leave, sick leave, or other similar benefits, shall be reimbursed if insured by an insurance carrier or shall take credit if self-insured, to the extent of all moneys that such employee may be eligible to receive as compensation for temporary partial or temporary total disability subject to the approval of the Director of the Colorado Division of Workers' Compensation.

Injury Description (Tell us the part of body that was affected. Tell us the nature of the injury/illness²; What was the employee doing just before the accident occurred?³; What happened?⁴; What object or substance directly harmed the employee?⁵)

- 2 Be more specific than ""hurt", "pain", or "sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."
- 3 Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."
- 4 Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."
- 5 Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank

Notices

You are hereby notified that if a child support obligation is owed, compensation benefits may be attached and payment of the child support obligation may be withheld and forwarded to the obligee pursuant to sections 8-42-124 and 26-13-122(4), C.R.S. YOU ARE FURTHER NOTIFIED that you must provide written notice of any award for social security, pension, disability or other source of income that might reduce your compensation benefits. This notice must be sent to the insurance carrier or self-insured employer within 20 days after learning of the payment or award. Failure to report may result in suspension of your benefits pursuant to section 8-42-113.5, C.R.S.

C.R.S. Section 10-1-128(6) (a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT DIVISION OF WORKERS' COMPENSATION

Colorado Workers' Compensation Information

Your employer has workers' compensation coverage for employees through:
Workers' compensation is a type of insurance coverage that employers must provide to their employees. The cost of workers' compensation insurance is paid entirely by the employer and may not be deducted from an employee's wages.
If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT. If you don't report your injury or occupational disease promptly your benefits may be reduced.
If you are unable to work as the result of a work-related injury or occupational disease, compensation (wage replacement) benefits will be based on 2/3 of your average weekly wage up to a maximum set by law. No compensation is payable for the first 3 days' disability unless the period of disability exceeds two weeks.
You are entitled to reasonable and necessary medical treatment of compensable injuries or occupational diseases. If you notify your employer of an injury or occupational disease and are not offered medical care, you may select the services of a licensed physician or chiropractor.
You may file a Worker's Claim for Compensation with the Division of Workers' Compensation. To obtain forms or information regarding the workers' compensation system, you may call Customer Service at 303-318-8700 or toll-free at 1-888-390-7936 or visit our website at www.colorado.gov/cdle/dwc.
COLORADO DIVISION OF WORKERS' COMPENSATION 633 17th Street, Suite 400, Denver, CO 80202-3626
Any information provided below comes from your employer and is specific to this place of employment: