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

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 Connecticut
Workers' Compensation Commission

Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011

Rev. 7-13-2009

FRI

Date filed in Chairman's Office

(for WCC use only)

Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

Employer *(Name, Address & Zip)* | Phone #

SIC Code | FEIN

Carrier / Administrator Claim # | OSHA Log Case # | Report Purpose Code

Jurisdiction | Jurisdiction Claim #

Employer's Location Address *(if different)* | Phone #

Carrier *(Name, Address & Zip)* | Phone #

Claims Administrator *(Name, Address & Zip)* | Phone #

Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
☐ Male
☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

Occupation / Job Title

Rate of Pay $ _____ . _____ per
☐ Hour ☐ Day ☐ Week ☐ Bi-Weekly ☐ Other

NCCI Class Code

Date of Injury / Illness *(MM/DD/YY)*

Time Employee Began Work ☐ a.m. ☐ p.m.

Time of Occurrence ☐ cannot be determined ☐ a.m. ☐ p.m.

Date Employer Notified *(MM/DD/YY)*

Date Disability Began *(MM/DD/YY)*

Date Last Worked *(MM/DD/YY)*

Date Return(ed) to Work *(MM/DD/YY)*

If Fatal, Date of Death *(MM/DD/YY)*

All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:

Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:

Contact Name

Phone #

Town of Injury / Illness

Did Injury / Illness occur on Employer's Premises? ☐ Yes ☐ No

Type of Injury / Illness

Part of Body Affected

Type of Injury / Illness Code

Part of Body Affected Code

Were Safeguards or Safety Equipment provided? ☐ Yes ☐ No

If provided, were they used? ☐ Yes ☐ No

How Injury / Illness Occurred — Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:

Cause of Injury Code

Physician / Health Care Provider *(Name, Address & Zip)*

Hospital *(Name, Address & Zip)*

Initial Treatment

☐ No Medical Treatment
☐ Minor — by Employer
☐ Minor — by Clinic / Hospital
☐ Emergency Care
☐ Hospitalized More Than 24 Hours
☐ Future Major Medical — Lost Time Anticipated

Date Administrator Notified *(MM/DD/YY)* | Date Prepared *(MM/DD/YY)*

Preparer's Name & Title | Phone #

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Policy / Self-Insured # | ☐ Check, if Self-Insured

Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name | First Name | Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
☐ Male
☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

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Policy Period *(MM/DD/YY)*
FROM: TO:

Employee: Last Name First Name Middle Name

D.O.B. *(required)* | Phone #

Address *(incl. Zip)*

Gender
☐ Male
☐ Female

Date Hired *(MM/DD/YY)* | State of Hire

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State of Connecticut Workers' Compensation Commission

Notice to Employees

Workers' Compensation Act

Chapter 568 of the Connecticut General Statutes (the Workers' Compensation Act) requires your employer,

_____

to provide benefits to you in case of injury or occupational disease in the course of employment.

Section 31-294b of the Workers' Compensation Act states: "Any employee who has sustained an injury in the course of his employment shall immediately report the injury to his employer, or some person representing his employer. If the employee fails to report the injury immediately, the commissioner may reduce the award of compensation proportionately to any prejudice that he finds the employer has sustained by reason of the failure, provided the burden of proof with respect to such prejudice shall rest upon the employer." Such an injury report by the employee is NOT an official written notice of claim for workers' compensation benefits. (The Form 30C is necessary to satisfy this requirement.)

The INSURANCE COMPANY or SELF-INSURANCE ADMINISTRATOR is:

Name _____

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

Approved Medical Care Plan ☐ Yes ☐ No

The State of Connecticut Workers' Compensation Commission office for this workplace is located at:

Address _____ Telephone _____

City/Town _____ State _____ Zip Code _____

Any questions as to your rights under the law or the obligations of the employer or insurance company should be addressed to the employer, the insurance company or the Workers' Compensation Commission (1-800-223-9675).

THIS NOTICE MUST BE IN TYPE OF NOT LESS THAN TEN POINT BOLD-FACE AND POSTED IN A CONSPICUOUS PLACE IN EACH PLACE OF EMPLOYMENT. FAILURE TO POST THIS NOTICE WILL SUBJECT THE EMPLOYER TO STATUTORY PENALTY (Section 31-279 C.G.S.).

Date Posted _____

Rev. 8-31-2004

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INSURANCE GROUP

IMPORTANT NOTICE

State of Connecticut
Workers' Compensation
Sec. 31-316. EMPLOYERS TO RECORD AND REPORT INJURIES
Each employer shall keep a record of such injuries sustained by his employees in the course of their employment as result in incapacity for one day or more; and each such employer shall send to the commissioner, in duplicate, each week, or oftener if so directed, such report of such injuries as the rules prescribed by the board of commissioners determine, with such notices of claims for compensation as have been served upon him within one week, in conformity with the provisions of section 31-294. No other report of injuries to employees shall be required by any department or office of the state from employers. The duplicates of such reports shall be immediately transmitted to the labor commissioner.

Sec. 31-316-1 ACCIDENTS REPORTS
An accident report, on Form 15, shall be filed with the commissioner having jurisdiction, in duplicate, within the week following the date of accident, for each accident resulting in either total or partial incapacity of one day or more. Such report does not constitute admission of liability. Noncompliance with this section is subject to the penalty provided in section 31-299 of the general statutes.