

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.

District of Columbia Government
Office of Worker's Compensation
P.O. Box 56098
Washington, DC 20011
(202) 671-1000

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Date of This Report _____

Employee Social Security No. _____

Employer Identification No. _____

Insurer No. _____

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

Employee Name and Address:	Employer Name and Address:	Insurer Name and Address:

IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of his/her's employees, but no later than ten days thereafter. Failure to file this form shall be subject to civil penalty not to exceed \$1,000.

Date and time of Injury _____ am/pm? Day of the week? _____

Normal starting time _____ am/pm? If employee back to work, give date and time _____ am/pm?

At what wage? _____ If fatal, give date of death _____ (file supplement report)

Date of disability began? _____ am/pm? Was the injured paid in full for this day? _____

Was the injured given Form No. 7 DCWC? _____ Foreman _____

When did you or the foreman first learn of the injury? _____

Male _____ Female _____ DOB _____ Employee's Telephone No. _____

Occupation when injured? _____ Was this his/her regular occupation? _____

(Department or branch regularly employed) _____

Was the injured hired in DC? _____ How long employed by you? _____

Piece or time worker? _____ Hourly wage? _____ Hours worked/day _____

Daily wages _____ Days worked per week _____ Average weekly earnings _____

If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week or month: _____

Employer's principal business function in DC _____

Employer's Telephone No. _____ Insurance Policy No. _____

Location of plant or place where accident occurred: _____

On employer's premises? _____

Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: _____

Name of Witnesses _____

Nature and location of injury (Describe fully): _____

Attending Physician and Address (If Hospital Involved - Indicate):

Name of Person Completing Form

Name (Please Print or Type)

Signature

Official Position

**DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION**

PO BOX 56098 • WASHINGTON, DC 20011 • (202) 671-1000 • (202) 671-1929 (fax)

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NOTICE OF COMPLIANCE

TO EMPLOYEES

1. You are required by law to report promptly to your employer and the Office of Workers' Compensation an occupational injury or disease, even if you deem it to be minor. Form No. 7 DCWC, Notice of Accidental Injury or Occupational Disease, to be obtained from the employer or the Office of Workers' Compensation, must be used for that purpose. After you have completed and signed it, you should mail it to the Office of Workers' Compensation at the above address, and to your employer.
2. You are entitled, if required, to the services of a physician or hospital of your choice and lost wages. Call (202) 671-1000 for information.
3. You may not sue your employer as a result of a work-connected injury or disease by reason of your exclusive remedy under the Workers' Compensation Law.
4. In order to preserve your right to benefits under the DC Workers' Compensation Law, you must file a written claim on Form No. 7A. DCWC, Employee's Claim Application, within one (1) year after your injury, or within (1) year after the last payment of benefits.
5. If you desire information regarding your rights and obligations prescribed by law, you may call your employer first. If you need further information you may call the Office of Workers' Compensation at (202) 671-1000.
6. The law gives you the right to be represented if you so desire.

TO EMPLOYERS

1. You are required to have Workers' Compensation insurance coverage if you have 1 or more employees.
2. You are required to display this poster at each worksite so that it will be of the greatest possible benefit to your employees.
3. You must file an Employer's First Report of Injury or Occupational Disease, Form No. 8 DCWC, with the Office of Workers' Compensation, copy to the nearest claim office of your insurer, on all occupational injuries or disease, as soon as possible, but no later than 10 days after the date of knowledge thereof.
4. Your employee must file Form No. 7 DCWC, Employee's Notice of Accidental Injury or Occupational Disease. Please provide your employee with Form No. 7 DCWC and direct them to complete it and return it to you and the Office of Workers' Compensation. Once you have received notice from the employee, you are required to send the employee a notice of his/her rights and obligations by certified mail, return receipt requested.
5. You are required to report to the Office of Workers' Compensation, and your insurer, and disability of more than 3 days which was not previously reported, as soon as possible, but no later than 10 days after the date of knowledge thereof.
6. You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee.
7. You are required to obtain from the insurer identified below a supply of all required Workers' Compensation Forms, or you may download the forms and notice mentioned above at our website <http://does.dc.gov>

NOTICE: Violation of the various provisions of the Workers' Compensation law provides for civil penalties.

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations

NAME OF INSURANCE COMPANY

NAME OF EMPLOYER

BY _____

Employer ID Number
(if number unknown, employer to request from IRS)

THIS NOTICE IS TO BE POSTED CONSPICUOUSLY IN AND ABOUT EMPLOYER'S PLACE(S) OF BUSINESS