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.

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

The law requires the employer to furnish the injured employee a copy of this report.

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

CASE NUMBER

IDENTIFICATION SECTION

NOTE: DO NOT WRITE IN SHADED BLOCKS

EMPLOYEE NAME - LAST	FIRST	M.I.	SOC SEC NO	DATE OF BIRTH MM / DD / YY	SEX MALE FEMALE	MARITAL STATUS MARRIED SINGLE	DATE RECEIVED MM / DD / YY

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

PHONE	OCCUPATION	DATE HIRED MM / DD / YY	YRS EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC. CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED MM / DD / YY	DATE OF INJURY/ILLNESS MM / DD / YY	PREFAB WC-2 WC-5	DOL NUMBER	DBA

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS ____ AM ____ PM	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES YES NO	INDUSTRIAL CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)

TIME WORKSHIFT BEGAN ____ AM ____ PM

SOURCE OF INJURY

EVENT

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)

TASK | ACTIVITY | ACCIDENT FACTOR

AOS

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED _____

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT				
BURNS				

TIME LOST INFORMATION

DATE DISABILITY BEGAN MM / DD / YY	WAS EMPLOYEE FURNISHED MEALS OR LODGING YES NO	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE MM / DD / YY	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ ILLNESS YES NO	IF EMPLOYEE DIED GIVE DATE MM / DD / YY	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIANS I.D. CODE

NAME OF MEDICAL FACILITY	ADDRESS	INPATIENT OVERNIGHT? YES NO / EMERGENCY ROOM ONLY? ☐

INSURANCE

CARRIER I.D.

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY: John Mullen & Co.,Inc. P.O. Box 2096 Honolulu,Hawaii 96805	IF LIABILITY DENIED -- WHY?	IS LIABILITY DENIED? YES NO

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO.

ADJUSTER I.D.	MEDICAL DEDUCTIBLE

SIGNATURE

	TITLE	DATE MM / DD / YY

(REV. NOV/01)

Every work injury to an employee causing absence for one day or more or which requires medical services other than first aid treatment must be reported within 7 working days after the injury. Failure to report promptly is a misdemeanor punishable by not more than a $5,000 fine. (Sec. 386-95, H.R.S. NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN DEATH.) EVERY QUESTION MUST BE ANSWERED FULLY TO AVOID FURTHER CORRESPONDENCE.

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WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

CASE NUMBER

IDENTIFICATION SECTION

NOTE: DO NOT WRITE IN SHADED BLOCKS

EMPLOYEE NAME - LAST	FIRST	M.I.	SOC SEC NO	DATE OF BIRTH MM / DD / YY	SEX MALE FEMALE	MARITAL STATUS MARRIED SINGLE	DATE RECEIVED MM / DD / YY

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

PHONE	OCCUPATION	DATE HIRED MM / DD / YY	YRS EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC. CODE

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED MM / DD / YY	DATE OF INJURY/ILLNESS MM / DD / YY	PREFAB WC-2 WC-5	DOL NUMBER	DBA

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS ____ AM ____ PM	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES YES NO	INDUSTRIAL CODE

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)

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SOURCE OF INJURY | EVENT

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TASK | ACTIVITY | ACCIDENT FACTOR

AOS

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED _____

	YES NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT			
BURNS			

TIME LOST INFORMATION

DATE DISABILITY BEGAN MM / DD / YY	WAS EMPLOYEE FURNISHED MEALS OR LODGING YES NO	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE MM / DD / YY	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ ILLNESS YES NO	IF EMPLOYEE DIED GIVE DATE MM / DD / YY	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIANS I.D. CODE

NAME OF MEDICAL FACILITY	ADDRESS	YES NO INPATIENT OVERNIGHT? EMERGENCY ROOM ONLY? ☐

INSURANCE

CARRIER I.D.

John Mullen & Co.,Inc.
P.O. Box 2096
Honolulu,Hawaii 96805

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED -- WHY?	IS LIABILITY DENIED? YES NO

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO.

ADJUSTER I.D.	MEDICAL DEDUCTIBLE

SIGNATURE

	TITLE	DATE MM / DD / YY

(REV. NOV/01)

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CASE NUMBER

IDENTIFICATION SECTION

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				MM / DD / YY	MALE FEMALE	MARRIED SINGLE	MM / DD / YY

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE

PHONE	OCCUPATION	DATE HIRED	YRS EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC. CODE
		MM / DD / YY				

REGISTERED EMPLOYER	DBA

ADDRESS	CITY	STATE	ZIP CODE

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	PREFAB	DOL NUMBER	DBA
		MM / DD / YY	MM / DD / YY	WC-2 WC-5		

DETAIL OF INJURY / ILLNESS

TIME OF INJURY/ILLNESS	TIME OF I/I CODE	PLACE OF I/I IF DIFFERENT FROM EMPLOYER'S MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES	INDUSTRIAL CODE
____ AM ____ PM					YES NO	

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary)

TIME WORKSHIFT BEGAN ____ AM ____ PM

SOURCE OF INJURY | EVENT

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using)

TASK | ACTIVITY | ACCIDENT FACTOR

AOS

OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him; the vapor or poison inhaled or swallowed; the chemical that irritated his skin. In cases of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT				
BURNS				

TIME LOST INFORMATION

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS OR LODGING	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ ILLNESS	IF EMPLOYEE DIED GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS WKED / WK	WEIGHING FACTOR
MM / DD / YY	YES NO		MM / DD / YY	YES NO	MM / DD / YY				

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIANS I.D. CODE

NAME OF MEDICAL FACILITY	ADDRESS	YES NO
		INPATIENT OVERNIGHT? EMERGENCY ROOM ONLY? ☐

INSURANCE

CARRIER I.D.

John Mullen & Co.,Inc.
P.O. Box 2096
Honolulu,Hawaii 96805

NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED – WHY?	IS LIABILITY DENIED? YES NO

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARRIER CASE NO.

ADJUSTER I.D.	MEDICAL DEDUCTIBLE

SIGNATURE

	TITLE	DATE
		MM / DD / YY

(REV. NOV/01)

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-14
EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

Instructions

Please completely fill out the WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail
Department of Labor and Industrial Relations, Disability Compensation Division
P.O. Box 3769, Honolulu, Hawaii 96812-3769

Delivery In-Person
Department of Labor and Industrial Relations, Disability Compensation Division
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

Delivery via Fax
Department of Labor and Industrial Relations, Disability Compensation Division
(808) 586-9219

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

FORM WC-14 EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS

EMPLOYEE'S WAGE-REPORT FOR FIFTY-TWO WEEKS PRIOR TO DATE OF INJURY

Employee:	SS No.:	Case No.: - -	Date of Injury:

The above employee reported employment with your firm Under the Hawaii Workers' Compensation Law; an employee's benefits are calculated based on wages earned. Please assist us in determining benefits by completing this form

Employer:	Employee's Occupation:	Hourly Rate:
Date Employed:	Presently Employed?	If terminated, date:
Disabled from:	through:	Returned to Work:

Indicate the days and hours normally worked:

Sunday: ☐	Monday: ☐	Tuesday: ☐	Wednesday: ☐	Thursday: ☐	Friday: ☐	Saturday: ☐

If other than the above, please indicate:

Please call Records and Claims Branch at 586-9174 if you have Questions

Employer:	Telephone: ( )
Address	
Date:	By:

(To be signed in ink)

Auxiliary aids and services are available upon request. Please call: (808) 586-9174; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall, on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation, be subjected to discrimination, excluded from participation in, or denied the benefits of the Department's services, programs, activities, or employment.

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

Employee:	SS No.:	Case No.: - -	Date of Injury:

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
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26										
	Total									

This statement of Employee's earnings is taken from our Payroll Records.

	Dates (inclusive) of each period paid for			Hours, Days, Weeks or month each Payment Covers	Total amount paid Employee for each period		Amount paid excluding overtime or extra work		Overtime or extra work	
	From	To	Year							
27										
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52										
	Total									

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