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 Aliance 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® are registered service marks of 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.

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.

		1 4					1		CAC.	SE NUMBER
IDENTIFICATION OF			IPLOYER'S RE						CAS	DE NUMBER
IDENTIFICATION S	SECTION	FIRST	E: DO NOT W	***************************************	HADED		F BIRTH	SEX	MARITAL STA	TUD
			"""	Luc ozo No		DAILO	I BIXIII	MALE		TUS DATE RECEIVED
ADDRESS			ADDITIONAL	ADDRESS INFORM	ATION (O/O)	MM / E	CITY C	FEMALE	SINGL	7447 00 711
			ADDITIONAL	ADDRESS INFORM	411014 (0/0)		CHY		SI	ATE ZIP CODE
PHONE	OCCUPATION		DATE HIRED	Vpp rup'n	cope provi	THENT				
FILORE	OCCOPATION		DATE HIRED	YRS EMP'D	JODE DEPAR	RTMENT			PAYROLL COMP CLASS CODE	OCC. CODE
DECIOTEDED FUDI OVED			MM / DD / YY							
REGISTERED EMPLOYER					DBA					
ADDRESS						CITY			STA	ATE ZIP CODE
PHONE	NATURE OF BUSINESS	•	DATE INJURY	//ILLNESS REPORT	ED DATE O	F INJURY/ILLNESS	S PR	EFAB	DOL NUM	IBER DBA
			мм /	DD / YY	MM /	DD / YY	WC-2	WC-5		
DETAIL OF INJURY	/ ILLNESS				-				7.00	
TIME OF INJURY/ILLNESS	TIME OF I/I	CODE PLACE OF I	I IF DIFFERENT FROM EMPL	LOYER'S MAILING A	DDRESS	CITY		STATE	ON EMPLOYER'S	S INDUSTRIAL CODE
	1 1								PREMISES	
HOW DID THIS ACCIDENT OCC				nal disease.				SOURCE OF INJUF	YES NO	ENT
	Tell what happene	ed. Please use separal	e sheet if necessary)		TIM	E WORKSHIFT I	133		-	
					Ĺ	AM	ем 🖺			
	*									
WHAT WAS EMPLOYEE DOING	WHEN INJURED? (Pleas	e be specific. Identify t	ools, equipment or mater	ial the employee	was using)			TASK	ACTIVITY	ACCIDENT FACTOR
							Ш			
									AC	OS .
OBJECT OR SUBSTANCE THAT	DIRECTLY INJURED EMPL	OYEE (e.g. the machine	employee struck agains	t or struck him; th	e vapor or poi	son inhaled or s	wallowed;			
		ine chemical ina	t irritated his skin. In case	es of strains, the	ining he was ii	fting, pulling, etc	5.)			
								YES NO	NATURE OF INJ	
DESCRIBE IN DETAIL THE NAT	JRE OF THE INJURY, ILLNE	SS AND PART OF THE BO	DY AFFECTED				niario) la ri		NATURE OF INJ	URY PART OF BODY
							DISFIGUREM	ENI		
							BURNS			
THE LOST WESS									-	
DATE DISABILITY BEGAN W	MATION AS EMPLOYEE FURNISHEE	AVG WKLY WAGE	IF EMPLOYEE IS BACK TO	WAS EMPLOYEE	PAID IN IF	EMPLOYEE DIED	GIVE DATE L	HOURLY WAGE IN	MONTHI V SALADV	HRS WKED / WK WEIGHING
	MEALS OR LODGING		WORK GIVE DATE	FULL FOR DAY O		CIMI LOTEL DIED	CIVEDATE	IOOKEI WAGE	WONTHLY SALAKT	FACTOR
MM / DD / YY	YES NO		MM / DD / YY	YES			/ w			
TREATMENT OF	TAIN NAME OF TREATING	PHYSICIAN FROM EMPLO	YEE		G	IVE NAME AND AD	DRESS OF SI	JRVIVORS ON BAC	СК	
NAME OF PHYSICIAN			ADDRESS		****				PHYSICIANS	I.D. CODE
NAME OF MEDICAL FACILITY			ADDRESS	<u>-</u>						YES NO
									INPATIENT O	VERNIGHT?
	CARRIER I.D.				****				EMERGENCY	ROOM ONLY?
INSURANCE		John Mull	en & Co.,Ind	C.,						
NAME OF WC INSURANCE CAR		P.O. Box 2	2096		DENIED - WHY	r?	-			IS LIABILITY DENIED?
			.030 <u>Hawaii 9680</u>	15						YES NO
POLICY NO.	POLI	ICY PERIOD	iawaii 3000		TER NAME			CARRIE	R CASE NO.	,,,,
						ADJUSTER I.D.		MEDICAL	L DEDUCTIBLE	
SIGNATURE								CDIOAI		
	. H				TITLE			1		DATE
				l						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.

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

		WC-1 EN	IPLOYE	R'S	RFPC	ORT OF I	NDUST	RIAL INJU	IRY		CA	SE NUMBER	
IDENTIFICATION	SECTION	2020.000.000						BLOCKS					
EMPLOYEE NAME - LAST	· · · · · · · · · · · · · · · · · · ·	FIRST			M.J. SC	DC SEC NO		DATE OF	BIRTH	SEX	MARITAL STA	ATUS DAT	TE RECEIVED
								MM / D	D /YY	MALE FEMALE	MARRIED SING	LE MM	/ DD /YY
ADDRESS				ADDITIO	NAL ADD	RESS INFORMA	TION (C/O)		CITY			700000000000000000000000000000000000000	ZIP CODE
PHONE	OCCUPATION		DAT	E HIRED	· · · · · · · · · · · · · · · · · · ·	YRS EMP'D C	ODE DEPA	RTMENT	<u> </u>		PAYROLL COMP	OCC. COD	E
			,	,	,						CLASS CODE		
REGISTERED EMPLOYER			<u> </u>	DD /	YY		DBA						
ADDRESS								CITY			ST	ATE 2	ZIP CODE
PHONE	NATURE OF BUSINESS	3	· ·	DATE IN	JURY/ILL	NESS REPORTE	D DATE C	OF INJURY/ILLNESS	PF	REFAB	DOL NU	MBER	OBA
					,	,		, ,					
	<u> </u>		i	ММ	/ DI	D · / YY		DD / YY	WC-2	WC-5			
DETAIL OF INJURY													
TIME OF INJURY/ILLNESS	TIME OF I/I	CODE PLACE OF I	/I IF DIFFEREN	IT FROM	EMPLOYE	ER'S MAILING A	DRESS	CITY		STATE	ON EMPLOYER PREMISES	's INDUSTR	IAL CODE
AM :	— PM										YES NO	o	
HOW DID THIS ACCIDENT OC		ully the events that resuled. Please use separate				disease.			- 8	SOURCE OF INJUR	Ý E	VENT	
				,	,		TIN	ME WORKSHIFT E	BEGAN				
							200,000000				<u> </u>		
WHAT WAS EMPLOYEE DOING	WHEN INJURED? (Pleas	se be specific. Identify t	ools, equipm	nent or m	naterial th	he employee v	as using)		9	TASK	ACTIVITY	ACCII	DENT FACTOR
									L				
											A	os	
OBJECT OR SUBSTANCE THA	F DIRECTLY INJURED EMPL							oison inhaied or so lifting, pulling, etc					
						•		g,	-,				
										YES NO	NATURE OF IN	JURY PA	RT OF BODY
DESCRIBE IN DETAIL THE NAT	URE OF THE INJURY, ILLNE	ESS AND PART OF THE BO	DDY AFFECTE	D					DISFIGUREN	IENT			
-									BURNS				
												-	
TIME LOST INFOR	MATION												
	AS EMPLOYEE FURNISHE	D AVG WKLY WAGE	IF EMPLOYE			VAS EMPLOYEE		EMPLOYEE DIED	GIVE DATE	HOURLY WAGE IN	MONTHLY SALARY	HRS WKED /	WK WEIGHING
, ,	MEALS OR LODGING	1 .	WORK 6	SIVE DAT		ULL FOR DAY O LNESS							FACTOR
MM / DD / YY	YES NO		MM /	DD /	YY	YES	NO	MM DD GIVE NAME AND AD	/ YY	UDIANODO ON DAG	<u></u>	<u> </u>	
TREATMENT	STAIN NAME OF TREATING	PHYSICIAN FROM EMPLO	YEE				Ę	SIVE NAME AND AD	UNLOG UF S	OVAIAOLE CUARAC			
NAME OF PHYSICIAN				ADDF	RESS						PHYSICIANS	H.D. CODE	
NAME OF MEDICAL FACILITY				ADDF	RESS								YES NO
												OVERNIGHT? Y ROOM ONLY	? 🗖
. HEMILE .	CARRIER I.D.												
INSURANCE		John Mull	en & (Co.,	Inc.								
NAME OF WC INSURANCE CAR	RIER	P.O. Box				IF LIABILITY	DENIED - WH	HY?				IS LIABILI	TY DENIED?
		Honolulu,		ii 96	805							YES	NO
POLICY NO.	POL	ICY PERIOD					ER NAME			CARRIEF	R CASE NO.	1	
								ADJUSTER I.D.		MEDICAL	DEDUCTIBLE		
SIGNATURE							ĺ						
						L	TITLE			<u> </u>		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.

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

		1 110 4 -11									CAS	E NUMBER	
IDENTIFICATION 6	SECTION		IPLOYER'S E: Do No										
IDENTIFICATION S EMPLOYEE NAME - LAST	SECTION	FIRST	c. bo ne		SEC NO	HADEL	***************	ATE OF BIRTH		SEX	MARITAL STAT	US DAT	E RECEIVED
									Y FEMAL	MALE	MARRIED		, ,
ADDRESS			ADDI*	TIONAL ADDRI	ESS INFORMA	ATION (C/O)		V DD Y		.E	SINGL	200000000000000000000000000000000000000	/ DD /YY IP CODE
PHONE	OCCUPATION		DATE HIR	ED	YRS EMP'D (ODE DEP	ARTMENT	_			AYROLL COMP	OCC. CODE	
			,	,	- 1						CLASS CODE		
REGISTERED EMPLOYER				/ YY 18		DBA	-					l	
ADDRESS								CITY			STA	TE Z	IP CODE
PHONE	NATURE OF BUSINESS		DATE	: INJURY/ILLNE	ESS REPORTI	ED DATE	OF INJURY/IL	LNESS	PREFAB		DOL NUM	BER	DBA
			MA	, / DD	/ w	MM	/ DD /	_{YY}	wc-2 w	>-5			
DETAIL OF INJURY	// II I NECE						·	1		::::: !			
TIME OF INJURY/ILLNESS	TIME OF I/I	CODE PLACE OF I	I IF DIFFERENT FRO	M EMPLOYER	R'S MAILING A	DDRESS	CITY			STATE	ON EMPLOYER'S	INDUSTRI	AL CODE
	1 1										PREMISES		
HOW DID THIS ACCIDENT OCC	PM	illy the events that resu	Ited in injury or oc	cupational di	sease.				SOURCE	OF INJURY	YES NO	ENT	
	Tell what happene	ed. Please use separat	e sheet if necessa	ну)		ĮT.I	- 1	HIFT BEGAN					
						l	AM	i9	И				
WHAT WAS EMPLOYEE DOING	WHEN INJURED? (Please	e be specific. Identify to	ools, equipment o	r material the	employee v	was using)			77	.SK	ACTIVITY	ACCID	ENT FACTOR
									-		500700		
											AC	S	
OBJECT OR SUBSTANCE THAT	DIRECTI V IN II IRED EMPL	OVEE (e.g. the machine	employae struck	against or st	truck him: th	a vapor or n	oison inhala	d or cuallou	od:				
SELECT CITY SELECTION AND AND AND AND AND AND AND AND AND AN	Divisore: Moories Em E		t irritated his skin.						eu,				
DESCRIBE IN DETAIL THE NAT	URE OF THE INJURY, ILLNE	SS AND PART OF THE BO	DY AFFECTED							ES NO	NATURE OF INJ	JRY PAI	RT OF BODY
							-	_	UREMENT				
								BURNS					
TIME LOST INFOR	MATION											•	
	AS EMPLOYEE FURNISHED	AVG WKLY WAGE	IF EMPLOYEE IS B		AS EMPLOYEE		IF EMPLOYE	E DIED GIVE DA	ATE HOURLY	WAGE MON	ITHLY SALARY	HRS WKED /	WEIGHING
/ /	MEALS OR LODGING		WORK GIVE D	IL.L.	LL FOR DAY O		1		,		,		FACTOR
MM / DD / YY	YES NO		MM / DD	/ w	YES			DD / YY AND ADDRESS	OF SURVIVOR	S ON BACK			
	BTAIN NAME OF TREATING F	PHYSICIAN FROM EMPLO								1			
NAME OF PHYSICIAN			AD	DRESS							PHYSICIANS	I.D. CODE	

NAME OF MEDICAL FACILITY			AD	DRESS							INPATIENT O	VERNIGHT?	YES NO
	Taxabiga ta										EMERGENCY	ROOM ONLY	['] □
INCUDANCE	CARRIER I.D.	John Mull	an 9 Ca	lna									
INSURANCE NAME OF WC INSURANCE CAR	RIER	John Mull	en a co. Nama	.,mc.	IF LIABILITY	DENIED - W	HY?					ISTIABILI	Y DENIED?
		P.U. BOX 2	.U30			.,						YES	NO NO
POLICY NO.	POL	Honolulu,	nawaii 9	לטאטי	ADJUS	TER NAME			1	CARRIER CA	ASE NO.		
							ADJUSTER	I.D.		MEDICAL DE	EDUCTIBLE		
SIGNATURE													
		· "				TITLE	<u> </u>					DATE	
												мм /	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



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:		SSI	No.:	Case No).: -	Date of Injury:
The above e benefits are	mployee reported o	employment with y n wages earned.	our firm Under tl Please assist us	ne Hawaii Wo in determinin	rkers' Compen g benefits by c	sation Law; an employee's ompleting this form
Employer:		Employee	's Occupation:		Hourly Rate:	
Date Employe	ed:	Presently	Employed?		If terminated, d	ate:
Disabled from:		through:			Returned to Wo	ork:
Indicate the da	ays and hours norma	lly worked:				
Sunday:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:
If other than th	ne above, please indi	cate:				
	Please	call Records and	Claims Branch a	t 586-9174 if s	vou have Ques	tions
Employer:			Teleph (one:		
Address			<u> </u>			
Date:			Ву:			
, , , , , , , , , , , , , , , , , , , ,					(To be signed in	n 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:	jury:
												a salahan adda wasan a		
Dates (i	Dates (inclusive) of each period paid for	f each	Hours, Days, Weeks or month each	Total amount paid	Amount paid excluding	Overtime or extra		Dates (ii	Dates (inclusive) of each	each	Hours, Days, Weeks or month each		Amount paid excluding	Overtime or extra
From	2	Year	Payment Covers	each period	overtime or extra work	work		From	70	Year	Payment Covers	each period	overtime or extra work	work
-							27							
2							28							
3							29							
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2							31							
9							32							
7							33							
80							34							
6							35				The state of the s			
10							38							
11							37							
12							38							
13							39							
14							40							
15		-					41							
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21							47							
22							48							
23							49							
24							20							
25					144		51							
26							52							
Total								Total						
This statemen	t of Employe	ee's earn	This statement of Employee's earnings is taken from our Payroll Records.	our Payroll Reco	ırds.		This	statement	f Employe	e's earning	s is taken from ou	This statement of Employee's earnings is taken from our Payroll Records.		