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.

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
Alternative Markets

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

General

Employer (Name & Address incl. zip)

Carrier/Administrator Claim Number | Report Purpose Code

Jurisdiction | Jurisdiction Claim No.

Insured Report No.

Employer's Location Address (if different) | Location No.

Phone No.

NAICS Code | Employer FEIN

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Carrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

Agent Name & Code Number

Employee

Legal Name (Last, First, Middle) | Birth Date | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/ Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number | Type of Illness/Injury | Part of Body Affected

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

Type of Illness/Injury Code | Part of Body Affected Code

Department or location where accident or illness exposure occurred | All Equipment, Materials, or Chemicals Employee Using upon Occurrence

Specific Activity Employee Engaged in at Time of Occurrence | Work Process the Employee Was Engaged in at Time of Occurrence

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill. | Cause of Injury Code

Date Returned to Work | If Fatal, Date of Death | Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No | Were they used? ☐ Yes ☐ No

Treatment

Physician/Health Care Provider (Name & Address)

Hospital (Name & Address)

Initial Treatment

0 ☐ No Medical Treatment
1 ☐ Minor: By Employer
2 ☐ Minor Clinic/Hosp
3 ☐ Emergency Care
4 ☐ Hospitalized – 24 hr.
5 ☐ Anticipated Major Med/Lost Time

Other

Signature of Injured Employee, or Signature on File, Date

Witness to Accident (Name & Phone Number)

Date Administrator Notified | Date Prepared | Preparer's Name & Title | Preparer's Phone Number

Filing this report is not an admission of liability. This report shall not be evidence of any fact stated herein in any proceeding in respect of the injury, illness or death on account of which this report is made. Idaho Industrial Commission, P.O. Box 83720, Boise, ID 83720-0041 IC Form IA-1 (08/2013)

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General

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NAICS Code | Employer FEIN | Phone No.

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)

Policy Period

To

☐ Check if self insured

Claims Admin (Name, Address & Phone Number)

Carrier FEIN | Policy Number or Self-Insured Number | Administrator FEIN

Agent Name & Code Number

Employee

Legal Name (Last, First, Middle) | Birth Date | Social Security Number | Date Hired | State of Hire

Address (Incl. Zip)

Sex: ☐ Male ☐ Female ☐ Unknown

Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown

Occupation/Job Title

Employment Status

Phone

No. of Dependents

NCCI Class Code

Wage Rate $ ☐ Day ☐ Week ☐ Month ☐ Other

Days Worked/WK

Hrs Worked per Day

Full Pay for Date of Injury? ☐ Yes ☐ No

Did Salary Continue? ☐ Yes ☐ No

Occurrence

Time Employee Began Work ☐ AM ☐ PM | Date of Injury or Illness | Time Occurred ☐ AM ☐ PM | Last Work Date | Date Employer Notified | Date Disability Began

Employer Contact Name/Phone Number | Type of Illness/Injury | Part of Body Affected

Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No | Type of Illness/Injury Code | Part of Body Affected Code

Department or location where accident or illness exposure occurred | All Equipment, Materials, or Chemicals Employee Using upon Occurrence

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Date Returned to Work | If Fatal, Date of Death

Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No

Were they used? ☐ Yes ☐ No

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Physician/Health Care Provider (Name & Address)

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		Phone No.
NAICS Code / Employer FEIN		

Carrier/Claims Admin

Carrier (Name, Address & Phone Number)	Policy Period / To / ☐ Check if self insured	Claims Admin (Name, Address & Phone Number)
Carrier FEIN	Policy Number or Self-Insured Number	Administrator FEIN
Agent Name & Code Number		

Employee

Legal Name (Last, First, Middle)	Birth Date	Social Security Number	Date Hired	State of Hire
Address (Incl. Zip)	Sex: ☐ Male ☐ Female ☐ Unknown	Marital Status: ☐ Unmarried/Single/Div. ☐ Married ☐ Separated ☐ Unknown	Occupation/Job Title	
Phone	No. of Dependents		NCCI Class Code	
Wage Rate $ ☐ Day ☐ Week	☐ Month ☐ Other	# Days Worked/WK / # Hrs Worked per Day	Full Pay for Date of Injury? ☐ Yes ☐ No / Did Salary Continue? ☐ Yes ☐ No	

Occurrence

Time Employee Began Work ☐ AM ☐ PM	Date of Injury or Illness	Time Occurred ☐ AM ☐ PM	Last Work Date	Date Employer Notified	Date Disability Began
Employer Contact Name/Phone Number		Type of Illness/Injury		Part of Body Affected	
Did Injury/Illness Exposure Occur on Employer's Premises? ☐ Yes ☐ No		Type of Illness/Injury Code		Part of Body Affected Code	
Department or location where accident or illness exposure occurred		All Equipment, Materials, or Chemicals Employee Using upon Occurrence			
Specific Activity Employee Engaged in at Time of Occurrence		Work Process the Employee Was Engaged in at Time of Occurrence			
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Date Returned to Work	If Fatal, Date of Death	Were Safeguards or Safety Equipment Provided? ☐ Yes ☐ No			
		Were they used? ☐ Yes ☐ No			

Treatment

Physician/Health Care Provider (Name & Address)	Hospital (Name & Address)	Initial Treatment
		0 ☐ No Medical Treatment 1 ☐ Minor: By Employer 2 ☐ Minor Clinic/Hosp 3 ☐ Emergency Care 4 ☐ Hospitalized – 24 hr. 5 ☐ Anticipated Major Med/Lost Time

Other

Signature of Injured Employee, or Signature on File, Date	Witness to Accident (Name & Phone Number)	
Date Administrator Notified / Date Prepared	Preparer's Name & Title	Preparer's Phone Number

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TO THE EMPLOYER: THIS NOTICE MUST BE POSTED IN A CONSPICUOUS PLACE UPON YOUR PREMISES.

NOTICE

REGARDING WORKERS' COMPENSATION INSURANCE

ALL WORKERS EMPLOYED BY THE UNDERSIGNED ARE HEREBY NOTIFIED THAT THE EMPLOYER HAS COMPLIED WITH THE LAW AS TO SECURING THE PAYMENT OF COMPENSATION TO EMPLOYEES AND THEIR DEPENDENTS, IN ACCORDANCE WITH THE PROVISIONS OF THE WORKERS' COMPENSATION LAW.

_____
Employer

_____
Date

By _____
Employer's Authorized Agent

An employee receiving an injury by accident must immediately notify his/her supervisor, superintendent, or the undersigned, who will provide medical attendance.

Claim for compensation must be made in writing and given to the employer. Forms for giving notice of injury and making claim for compensation will be furnished by the employer; by the surety,

or upon application, by the Industrial Commission in Boise, Idaho.

I.C. Form 14

File No.

ORIGINAL
Mail to
Surety

Employer's Supplemental Report

Employer: Fill out this form in duplicate. Mail copy to Industrial Commission (P.O. Box 83720, Boise, Idaho 83720-0041) and the original to your workers' compensation insurer at the following times:

1. Upon termination of disability (regardless of length of time disabled for work).
2. At the end of 60 days from the date disability began if employee is disabled that long.

Any employer who fails to make this report upon termination of the disability of one of his insured employees and (if the disability extends beyond a period of 60 days) at the end of that period is subject to a penalty not to exceed $500.00.

<table>
<tr><td>Name of injured employee:</td><td>Address where mail should be sent:</td></tr>
<tr><td>Date of injury:</td><td>Date disability began:</td></tr>
<tr><td>Were wages paid for the day the disability began?
☐ Yes ☐ No</td><td>What wages, if any, have been paid during the period of disability?</td></tr>
<tr><td rowspan="2">Had the injured employee returned to work?
☐ Yes ☐ No</td><td>If so, on what date was he re-employed?</td></tr>
<tr><td>At what daily wage?</td></tr>
<tr><td>At light or regular work?
☐ Light duty ☐ Regular work</td><td>If re-employed at less wages than received before the injury, give reason:</td></tr>
<tr><td colspan="2">Give date the injured employee recovered sufficiently to return to regular work:</td></tr>
</table>

THE ABOVE STATEMENTS ARE CORRECT
(The employee MUST NOT sign this form BEFORE the work disability ceases)

_____
Employer

_____
Signature of injured employee

_____
Signature of Authorized Agent

Date of this report _____

Address _____

PARA EL PATRON: ESTE AVISO DEBE SER PUESTO EN UN LUGAR CONSPICUO EN SU SITIO DE NEGOCIO.

AVISO

RESPECTO A EL SEGURO DE COMPENSACIÓN PARA TRABAJADORES

TODOS LOS TRABAJADORES EMPLEADOS POR EL SUSCRITO SON, POR LA PRESENTE, NOTIFICADOS QUE EL PATRÓN HA CUMPLIDO CON LA LEY CON RESPECTO A ASEGURAR EL PAGO DE COMPENSACIÓN A LOS EMPLEADOS Y SUS DEPENDIENTES, DE ACUERDO CON LAS PROVISIONES DE LA LEY DE COMPENSACIÓN PARA TRABAJADORES.

_____
Patrón

_____
Fecha

Por _____
Agente Autorizado del Patrón

Un empleado que recibe un daño en un accidente tiene que notificar immediatamente a su mayordomo o mayordoma, superintendente o a la persona suscrita, quien proveera atención médica.

Reclamación para compensación tiene que ser hecha por escrito y entregada al patrón. Formas explicando el daño y reclamando compensación serán proveidas por el patrón; por el fiador,

o con solicitud, por La Comisión Industrial en Boise, Idaho.