

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.

ACCIDENT REPORT

K-WC 1101-A (Rev. 1-12)

– SEE INSTRUCTIONS ON PAGE 2 –

| |
|--|
| <p>Mail or fax ORIGINAL report to: Division of Workers Compensation 401 SW Topeka Blvd., Suite 2 Topeka, KS 66603-3105 Fax: (785) 296-4216</p> <p>Direct questions or comments to: Toll-free (800) 332-0353</p> |
|--|

There is a \$250 penalty for repeated failure to file accident reports within 28 days of the date the employer is informed of the accident. **Submission does not constitute admission of liability.**

OSHA Case or File Number _____

- Federal Employer's Identification Number _____ Date of hire _____
- Name of employer _____ Phone _____
- Mailing address _____
Street City State ZIP Code
- Location, if different from mailing address _____
Street City State ZIP Code
- Nature of business _____ NAICS or S.I.C. Code _____ Dept. or division _____
- Name of employee _____ Age _____ Sex _____
First Middle Last
- Home address _____
Street City State ZIP Code
- SSN _____ Birth date _____ Employee's occupation _____ Home phone _____
- Date of injury or occupational disease _____ Time of injury _____ a.m. p.m.
Date reported to employer _____ Date disability began _____ Gross average weekly wage \$ _____
- Place of accident or last exposure _____
City County State
- Was accident or last exposure on employer's premises? YES NO
- How did accident occur? _____
- What was employee doing when injured? _____
- Name substance or object that directly caused injury* _____
- Describe in detail nature and extent of injury, indicate part of body involved* _____
- Was worker admitted to hospital? YES NO Date _____ Treated by emergency room only? YES NO
Hospital name and address _____
- Name and address of attending physician or clinic _____
- Has employee returned to regular duty? YES NO Light duty? YES NO Date _____
- Is compensation now being paid? YES NO Date first/initial payment _____
- Weekly compensation rate \$ _____ Is further medical aid needed? YES NO UNKNOWN
- Did employee die? YES NO If YES, give date of death _____ (File amended report within 28 days if death subsequently occurs.)
- Name(s) and address(es) of dependents (death cases only) _____
- Insurance carrier and third party administrator _____
Address _____ Phone _____
Street City State ZIP Code
Policy number _____ Name of agent _____
Claim number _____ Name of claim representative _____
- Date of report _____ Completed by _____ Title _____

| |
|---|
| FOR OFFICE USE |
| COUNTY |
| CAUSE |
| NATURE |
| SEVERITY |
| 0 - NO TIME LOST 1 - TIME LOST 2 - MEDICAL 3 - FATAL |
| SOURCE |
| MEMBER |

Instructions

You must answer every question; failure to answer all questions may cause the report to be returned to the employer. Returned accident reports may cause a delay of benefits to the injured employees and could subject the employer to fines.

Mail or fax the **original** report only. If not completed using the fillable PDF form, the report must be printed neatly in black ink or typewritten. If not legible, the report will be returned which will delay timely processing.

The employer must send this accident report to its insurance carrier, third party administrator or pool association as indicated in the employer's insurance contract. **The employer is responsible for submitting the original report to the Division of Workers Compensation within 28 days of the date the employer is informed of the accident.**

*Instructions for Questions 14 and 15

14: Name the object or substance which directly injured the employee. Example: machine or object employee struck or struck employee; vapor or poison employee inhaled or swallowed; chemicals or radiation which irritated employee's skin; if hernia, the object employee was lifting or pulling; etc.

15: Be as specific as possible indicating all that is known about the injury. Name the part of body injured.

Definition of an Incapacitating Injury

The Workers' Compensation Act sets forth a strict time frame for filing accident reports with the division. The controlling statute is K.S.A. 44-557(a), which reads as follows:

(a) it is hereby made the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

Accident reports are not required for every work-related injury. The statute requires a report to be filed when the worker's whole or partial incapacity continues beyond the "day, turn, or shift which such injuries are sustained" as the result of accident. "Incapacity" is not specifically defined within the law, but the division believes that the Legislature's intent was to reference a worker's whole or partial loss of the ability to perform his or her ordinary job tasks. When in doubt, keep in mind the law contains no penalty for filing a report that ultimately proves to be unnecessary. **There are penalties, however, for failing to file a report when one was required.** The penalties include fines and limitations on the defenses the employer may assert if a claim is filed.

OSHA Recordkeeping

The employer must complete an Injury and Illness Incident Report, OSHA Form 301, within seven (7) days of learning that a work-related injury or illness has occurred. According to OSHA's recordkeeping rule, you must keep Form 301, or an equivalent substitute on file for five (5) years.

To learn more about OSHA's recordkeeping requirements and download forms, visit:

www.osha.gov/recordkeeping/RKforms.html

This notice must be posted and maintained by the employer in one or more conspicuous places.

Workers Compensation Rights and Responsibilities

Your employer is subject to the Kansas Workers Compensation Law which provides compensation for job-related injuries.

This notice applies to dates of accidents on or after April 25, 2013.

Este aviso aplica a las fechas de los accidentes a partir de Abril 25, 2013.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

NOTIFY YOUR EMPLOYER IMMEDIATELY. Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) **20 calendar days** from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, **20 calendar days** from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, **10 calendar days** after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

BENEFITS. Benefits are paid by the employer's insurance carrier or self insurance program. Benefits include medical treatment, partial wage replacement for lost time and additional benefits if the injury results in permanent disability. An employer is required to furnish all necessary medical treatment and has the right to designate the treating physician. If the employee seeks treatment from a doctor not authorized by the employer, the employer or its insurance carrier is only liable up to \$500.00 dollars for the unauthorized medical treatment.

QUE HACER SI UNA LESIÓN OCURRE EN EL TRABAJO

NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE. De acuerdo con el artículo de ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador dentro de antes de las siguientes fechas: (A) **20 días** a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, **20 días** a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, **10 días** después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

BENEFICIOS. Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los beneficios incluyen tratamiento médico, reemplazo de sueldo parcial por tiempo perdido y beneficios adicionales si la lesión resulta en incapacidad permanente. El empleador debe proporcionar todo el tratamiento médico necesario y tiene el derecho de designar el doctor para dicho tratamiento. Si el empleado busca tratamiento con un doctor que no ha sido autorizado por el empleador, el empleador o su compañía aseguradora serán responsables de pagar solamente los primeros \$500.00 dólares para tratamiento médico no autorizado.

WHERE TO GET HELP WITH YOUR CLAIM (DÓNDE CONSEGUIR AYUDA CON SU RECLAMO):

Employer's Insurance Carrier (Compañía Aseguradora del Empleador)

() _____
Telephone (Teléfono de la Aseguradora)

Address (Dirección de la Aseguradora)

For questions about Workers Compensation Law, contact (Para preguntas acerca de la Ley de Compensación del Trabajador):

KANSAS DEPARTMENT OF LABOR
Division of Workers Compensation/Ombudsman
401 SW Topeka Blvd., Suite 2, Topeka, KS 66603-3105

Website: www.dol.ks.gov/workcomp/default.aspx
Email: wc@dol.ks.gov
Phone: (800) 332-0353 or (785) 296-4000

Persons with impaired hearing or speech utilizing a telecommunications device may access the above number(s) by using the Kansas Relay Center at (800) 766-3777.

Department of Human Resources
DIVISION OF WORKERS COMPENSATION
600 Merchants Bank Tower, 800 S.W. Jackson
Topeka, Kansas 66612-1227

Notice of Handicap, Disability or Physical Impairment

Employer: _____

Address: _____
(Street) (City) (State) (Zip Code)

The following employees were hired and/or retained by this employer with full knowledge of a handicap, disability or physical impairment; pursuant to K.S.A. 44-566. Notice is hereby given to the Director pursuant to K.S.A. 44-567.

| | Name of Employee | Social Security Number | Date Employed | List Category Number (see below) * | Concise Description of the Nature of the Impairment |
|-----|------------------|------------------------|---------------|------------------------------------|---|
| 1. | _____ | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ | _____ | _____ |
| 9. | _____ | _____ | _____ | _____ | _____ |
| 10. | _____ | _____ | _____ | _____ | _____ |

(Employer or Agent)

(Date)

INSTRUCTIONS TO EMPLOYERS: List all employees known to have any handicap, disability or physical impairment, including psychoneurotic or mental disease or disorder. Employees who have sustained physical injury must be included if the resulting condition causes them to be more susceptible to future injury or if the injury resulted in permanent impairment. Separate entries are required for each identifiable disability. Be specific. The State of Kansas encourages the employment of handicapped persons, and filing this form with the state preserves certain legal defenses to which you may be entitled under the Kansas Workers Compensation laws. Questions regarding the use of this form should be directed to your insurance claims representative.

* For your information the law lists the following categories:

Indicate whether impairment is due to (1) epilepsy, (2) diabetes, (3) cardiac disease, (4) arthritis, (5) amputated foot, leg, arm or hand, (6) loss of sight of one or both eyes or a partial loss of vision of more than seventy-five percent (75%) bilaterally, (7) residual disability from poliomyelitis, (8) cerebral palsy, (9) multiple sclerosis, (10) Parkinson's disease, (11) cerebral vascular accident, (12) tuberculosis, (13) silicosis or asbestosis, (14) psychoneurotic or mental disease or disorder established by medical opinion or diagnosis, (15) loss of or partial loss of use of any member of the body, (16) any physical deformity or abnormality, (17) any other physical impairment, disorder or disease, physical or mental, which is established as constituting a handicap in obtaining or in retaining employment. (Such as prior back injury, muscle strains, etc.)

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that social security numbers be included on forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of social security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

INFORMATION FOR INJURED EMPLOYEES

K-WC 27 (Rev. 6-12)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER MAY 15, 2011 *

Employers are required to provide this information to each injured worker

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 30 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee is working for the employer against whom benefits are being sought and such employee seeks medical treatment for any injury by accident or repetitive trauma, 20 calendar days from the date such medical treatment is sought; or (C) if the employee no longer works for the employer against whom benefits are being sought, 20 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of \$500.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 $\frac{2}{3}$ percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Employers must report all employee injuries to the Division of Workers Compensation within 28 days from the date of injury, or the date the employer learned about the injury, when the employee is wholly or partially incapacitated for more than the remainder of the day, turn or shift.
2. Employers must provide for the payment of workers compensation claims without any charge to employees.
3. Employers must post the Workers Compensation Notice prepared by the Director.
4. Employers must pay compensation benefits, regardless of insurance coverage.
5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

YOUR CLAIM WILL BE HANDLED BY:

Company _____

Address _____

Contact Person _____

Phone (_____) _____

Email _____

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270 (Revisado 6-12)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE MAYO 15, 2011 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible.**

(1) NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 30 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado está trabajando con el empleador en contra del cual se están buscando beneficios y dicho empleado busca tratamiento médico por cualquier lesión por accidente o trauma repetitiva, 20 días a partir de la fecha que dicho tratamiento médico ha sido obtenido; o (C) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 20 días después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

(2) SIGA LAS INSTRUCCIONES DE SU EMPLEADOR para conseguir ayuda médica y siga las instrucciones del doctor.

(3) BENEFICIOS MÉDICOS: El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 500.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. El empleador debe reportar cada accidente de los trabajadores a la División of Compensación de Trabajadores dentro de 28 días de la fecha del accidente, o de la fecha en que el empleador se haya dado cuenta del accidente, cuando el trabajador esté completa o parcialmente incapacitado por lo que resta del día o del turno.
2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.
3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.
4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.
5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía _____

Dirección _____

Persona de Contacto _____

Teléfono (_____) _____

Correo electrónico _____