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® are registered service marks of 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)



GreatAmericanCaptive.com

Alternative Markets

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.

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS I	NCL ZIP)	CARRIER/ADMINISTRATO	R CLAIM NUMBER	OSHA LOG NUMBER	REPORT PURPOSE CODE		
		JURISDICTION	JURISDICTION JURISDICTION				
		INSURED REPORT NUMBE	INSURED REPORT NUMBER				
		EMPLOYER'S LOCATION A	ADDRESS (IF DIFFE	RENT)	LOCATION #		
INDUSTRY CODE	MPLOYER FEIN				PHONE #		
CARRIER/CLAIMS ADMIN CARRIER (NAME, ADDRESS, & PI		POLICY PERIOD	CLA	IMS ADMINISTRATOR (N	AME, ADDRESS & PHONE NO)		
		TO					
		TO					
			CHECK IF APPROPRIATE				
CARRIER FEIN	POLICY/SELF-INSURED NUM		1	ADMIN	ISTRATOR FEIN		
AGENT NAME & CODE NUMBER							
				,			
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURIT	YNUMBER DATE I	IRED STATE OF HIRE		
ADDRESS (INCL ZIP)		SEX	MARITAL STATUS	s occur	ATION/JOB TITLE		
		M MALE F FEMALE	U UNWARRIED SINGLE/DIVORCE	EMPLC	YMENT STATUS		
PHONE		F FEMALE U UNKNOWN # OF DEPENDENTS	M MARRIED S SEPARATED K UNKNOWN	NCCLO	LASS CODE		
PER:	DAY MONTH WEEK OTHER:	DAYS WORKEDWEEK	DID SALARY	R DAY OF INJURY? Continue?	YES NO YES NO		
		OF OCCURRENCE AM	LAST WORK DATE	DATE EMPLOYER	DATE DISABILITY		
BEGAN WORK	() CA	NNOT BE PM		NOTIFIED	BEGAN		
CONTACT NAME/PHONE NUMBER	TYPE OF INJURY/ILLNESS		PART OF BODY AFFECT	ΈD			
DID INJURY/ILLNESS/EXPOSURE OG PREMISES?	CCUR ON EMPLOYER'S T	TYPE OF INJURYALLNESS CODE		PART OF BODY AFFECT	ED CODE		
DEPARTMENT OR LOCATION WHER OCCURRED	O RE ACCIDENT OR ILLNESS EXPOSURE	E ALL EQUIPMENT, MA		CALS EMPLOYEE WAS US	VG WHEN ACCIDENT OR ILLNESS		
			.20				
SPECIFIC ACTIVITY THE EMPLOYEE ILLNESS EXPOSURE OCCURRED	E WAS ENGAGED IN WHEN THE ACCID	DENT OR WORK PROCESS TH	E EMPLOYEE WAS EN	GAGED IN WHEN ACCIDE	NT OR ILLNESS EXPOSURE		
HOW INJURY OR ILLNESS/ABNORM THE EMPLOYEE OR MADE THE EMP	AL HEALTH CONDITION OCCURRED. PLOYEE ILL	DESCRIBE THE SEQUENCE OF EV	ENTS AND INCLUDE	ANY OBJECTS OR SUBST	NCES THAT DIRECTLY INJURED		
				CAUSE	OF INJURY CODE		
DATE RETURN(ED) TO WORK IF FATAL, GIVE DATE OF DEATH WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES NO			
PHYSICIAN/HEALTH CARE PROVIDE	ER (NAME & ADDRESS)	WERE THEY USED? OSPITAL OR OFF SITE TREATMEN	IT (NAME & ADDRESS		YES NO		
					-		
					-{		
					-		
				4			
OTHER		·····		· · · · · · · · · · · · · · · · · · ·			
WITNESSES (NAME & PHONE #)							
DATE ADMINISTRATOR NOTIFIED	D DATE PREPARED PREPA	ARER'S NAME & TITLE			PHONE NUMBER		
FORM IA-1(r 1-1-02)	SEE BACK F	FOR IMPORTANT INFO	ORMATION	©IA	IABC 2002		

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status.		The valid choices are:
Full-Time	On Strike	Unknown
Part-Time	Disabled	Apprenticeship Full-Time
Not Employed	Retired	Apprenticeship Part-Time

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

Volunteer

Seasonal

Piece Worker

EMPLOYER'S INSTRUCTIONS – cont'd
ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Acetylene cutting torch, metal plate)
List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.
Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Cutting metal plate for flooring)
Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.
WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).
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Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.
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WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL	ZIP)	CAR	RIER/ADMINISTRATO	R CLAIM NUME	BER OSHALOGN	UMBER	REPORT PURPOSE CODE	
		JUR	JURISDICTION JU		JURISDICTIO	JURISDICTION CLAIM NUMBER		
		INSU	INSURED REPORT NUMBER					
		EMP	LOYER'S LOCATION A	ADDRESS (IF D	DIFFERENT)	LOCATION #		
INDUSTRY CODE EMPL	OYER FEIN						PHONE #	
CARRIER/CLAIMS ADMINIS							· · · · · · · · · · · · · · · · · · ·	
CARRIER (NAME, ADDRESS, & PHON	(E #)	POL	ICY PERIOD		CLAIMS ADMINISTR	ATOR (NAM	E, ADDRESS & PHONE NO)	
			TO					
		CHEC	X IF APPROPRIATE					
CARRIER FEIN	POLICY/SELF-INSURE		SELFINSURANCE			ADMINIST	RATOR FEIN	
AGENT NAME & CODE NUMBER								
AGENT NAME & CODE NOMBER								
EMPLOYEE/WAGE			E OF BIRTH		CURITY NUMBER	DATE HIR	ED STATE OF HIRE	
ADDRESS (INCL ZIP)		SEX	MALE	MARITAL ST			ION/JOB TITLE	
		F	FEMALE UNKNOWN	M MARRIE	IVORCED D	EMPLOTIN	IENT STATUS	
PHONE		-	DEPENDENTS	S SEPARA K UNKNON		NCCI CLASS CODE		
RATE PER:	DAY MON WEEK OTHE		DAYS WORKEDWEEK		Y FOR DAY OF INJU ARY CONTINUE?	RY?	YES NO YES NO	
OCCURRENCE/TREATMEN		I	· · · · · · · · · · · · · · · · · · ·					
TIME EMPLOYEE AM DAT BEGAN WORK PM	E OF INJURY/ILLNESS	TIME OF OCCURE () CANNOT BE	RENCE AM	LAST WORK	DATE DATE EMPLO	Oyer	DATE DISABILITY BEGAN	
CONTACT NAME/PHONE NUMBER		DETERMINED	JURYALLNESS		PART OF BOD	Y AFFECTED		
DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S TYPE OF IN			JURY/ILLNESS CODE		PART OF BOD	Y AFFECTED	CODE	
PREMISES? VES NO DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPL			HEMICALS EMPLOYEE	WAS USING	WHEN ACCIDENT OR ILLNESS			
OCCURRED			EXPOSURE OCCURR	ΈD				
SPECIFIC ACTIVITY THE EMPLOYEE WA	S ENGAGED IN WHEN THE	ACCIDENT OR	WORK PROCESS THI OCCURRED	E EMPLOYEE W	AS ENGAGED IN WHE	N ACCIDENT	OR ILLNESS EXPOSURE	
			OUCONNED					
HOW INJURY OR ILLNESS/ABNORMAL H THE EMPLOYEE OR MADE THE EMPLOY	EALTH CONDITION OCCU	RRED. DESCRIBE	THE SEQUENCE OF EV	ENTS AND INC	LUDE ANY OBJECTS O	R SUBSTANC	ES THAT DIRECTLY INJURED	
						CAUSE OF	INJURY CODE	
DATE RETURN(ED) TO WORK	F FATAL, GIVE DATE OF DI		AFEGUARDS OR SAFET	Y EQUIPMENT	PROVIDED?			
PHYSICIAN/HEALTH CARE PROVIDER ()	IAME & ADDRESS)		HEY USED? DR OFF SITE TREATMEN	IT (NAME & ADD	DRESS)		S NO IAL TREATMENT	
						0	NO MEDICAL TREATMENT	
						1	MINOR: BY EMPLOYER MINOR CLINIC/HOSP	
						3	EMERGENCY CARE	
						4	HOSPITALIZED > 24 HOURS	
						5	FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
OTHER WITNESSES (NAME & PHONE #)								
DATE ADMINISTRATOR NOTIFIED	DATE ADMINISTRATOR NOTIFIED DATE PREPARED PREPARER'S NAME & TITLE			PHONE NUMBER				
FORM IA-1(r 1-1-02)	SEE BA	CK FOR IM	PORTANT INFO	ORMATIO	N	©IAIA	BC 2002	

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

Enter all dates in MM/DD/YY format.

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee	e's work status.	The valid choices are:
Full-Time	On Strike	Unknown
Part-Time	Disabled	Apprenticeship Full-Time
Not Employed	Retired	Apprenticeship Part-Time

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

Volunteer

Seasonal Piece Worker

EMPLOYER'S INSTRUCTIONS - cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

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:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS IN	ICL ZIP)	CAF	RIER/ADMINISTRATO	R CLAIM NUM		OSHA LOG N			RT PURPOSE CODE	
		JUR	JURISDICTION		JURISDICTION CLAIM NU		UMBER			
		IN CI	INSURED REPORT NUMBER							
		100		14						
		EMP	LOYER'S LOCATION A	NDDRESS (IF I	DIFFER	ENT)		LOCAT	ION #	
INDUSTRY CODE EM	PLOYER FEIN	-						PHONE	= #	
								<u> </u>		
CARRIER/CLAIMS ADMIN CARRIER (NAME, ADDRESS, & PH		POL	ICY PERIOD		CLAII	MS ADMINISTR	ATOR (NA	ME, ADDRE	ESS & PHONE NO)	
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		CHE	CK IF APPROPRIATE							
CARRIER FEIN	POLICY/SELF-INSURED NUM		SELF INSURANCE					TRATOR F	CIN	
		ULIX					ADMINIC	INALOK	CIN	
AGENT NAME & CODE NUMBER										
EMPLOYEE/WAGE			<u> </u>							
NAME (LAST, FIRST, MIDDLE)		DAT	e of Birth	SOCIAL SE	CURITY	NUMBER	DATE HI	RED	STATE OF HIRE	
ADDRESS (INCL ZIP)		SEX		MARITAL S	TATUS	· · · ·	OCCUP	TION/JOB	TITLE	
			MALE	U UNVARR SUNCLEAD	ED		EMPLOY	MENT STA	TUS	
			FEMALE UNKNOWN	M MARRIE S SEPARA	D					
PHONE				NCCI CL	NCCI CLASS CODE					
RATE PER:	DAY MONTH WEEK OTHER:	 	DAYS WORKED/WEEK			DAY OF INJUP	RY?			
OCCURRENCE/TREATME		l		DID SAL	ARTU	ONTINUE?			ES NO	
		FOCCUR	RENCE AM	LAST WORK	DATE	DATE EMPLO	DYER		TE DISABILITY GAN	
PM	() CAN DETER	NOT BE	PM			INVITIED		DEV	ЗАЛ	
CONTACT NAME/PHONE NUMBER	T I	YPE OF IN	JURYALLNESS	-		PART OF BOD	/ AFFECTE	D		
DID INJURYALLNESS/EXPOSURE OCC PREMISES?	CUR ON EMPLOYER'S TY	PE OF IN	JURY/LLINESS CODE			PART OF BOD	AFFECTE	D CODE		
VES NO DEPARTMENT OR LOCATION WHERE	ACCIDENT OR ILLNESS EXPOSURE		ALL EQUIPMENT, MA	TERIALS, OR C	HEMIC		WAS USING	WHEN AC	CIDENT OR ILL NESS	
OCCURRED			EXPOSURE OCCURR	ED						
SPECIFIC ACTIVITY THE EMPLOYEE V	WAS ENGAGED IN WHEN THE ACCID	ENTOR	WORK PROCESS THE	ENDLOYEE	VAC EN					
ILLNESS EXPOSURE OCCURRED	The Electored in Miler McAdob	LINI OR	OCCURRED	- CMPEQUEE I	INO ENV	SAGED IN MAEI	ACCIDEN		SS EXPOSURE	
HOW INJURY OR ILLNESS/ABNORMAI THE EMPLOYEE OR MADE THE EMPL	L HEALTH CONDITION OCCURRED. I OYEE ILL	DESCRIBE	THE SEQUENCE OF EV	ENTS AND INC	LUDE A	NY OBJECTS OF				
							CAUSEC	of injury c	2002	
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE S	AFEGUARDS OR SAFET	Y EQUIPMENT	PROVID	DED?		S	NO	
PHYSICIAN/HEALTH CARE PROVIDER	(NAME & ADDRESS) H		HEY USED? DR OFF SITE TREATMEN	T (NAME & ADI	DRESS)		YE N	TIAL TREAT	NO IMENT	
							0	NO MEDIO	CAL TREATMENT	
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							2		UNIC/HOSP NCY CARE	
							4		UZED > 24 HOURS	
· · · · ·							5	FUTURE M	AJOR MEDICAL/ ANTICIPATED	
OTHER WITNESSES (NAME & PHONE #)										
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED PREPA	RER'S NA	ME&TITLE				Pł	PHONE NUMBER		
FORM IA-1(r 1-1-02) SEE BACK FOR IMPORTANT INFORMATION @					ABC 200] n2				
		577 HV					SIAI/	.00 200	<i></i>	

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS

DATES:

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AGENT NAME & CODE NUMBER:

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OCCUPATION/JOB TITLE:

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EMPLOYMENT STATUS:

Indicate the employe	e's work status.	The
Full-Time	On Strike	
Part-Time	Disabled	
Not Employed	Retired	

valid choices are: Unknown Apprenticeship Full-Time Apprenticeship Part-Time

Volunteer Seasonal Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

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TYPE OF INJURY/ILLNESS:

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PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd
ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED: (eg. Acetylene cutting torch, metal plate)
List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.
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DATE RETURN(ED) TO WORK: Enter the date following to most recent disability period on which the employee returned to work.



COMMONWEALTH OF KENTUCKY WORKERS' COMPENSATION NOTICE

Employees of this business are covered by the Kentucky Workers' Compensation Act (KRS Chapter 342). Conspicuous posting of this Notice is required by law.

Employer Name:			
Address:			
Workers Compensation Carrier			
(or third party administrator):			
Policy #:	, effective	to	
Address:			
Telephone:	, Contact Person		

EMPLOYEES: IF INJURED – NOTIFY your supervisor IMMEDIATELY; when possible Notice should be in writing. FAILURE to notify your supervisor could result in denial of benefits. OBTAIN MEDICAL CARE. Your employer must pay for ALL NECESSARY MEDICAL CARE to treat a workplace injury. The employee may select the physician or medical facility to render care. If the employer is enrolled in an approved Managed Care Plan employee selection of physicians is LIMITED to the Approved Provider Network, except in certain emergencies. FOR INJURIES REQUIRING CONTINUING CARE the EMPLOYEE MUST DESIGNATE A TREATING PHYSICIAN, a form to do so will be furnished by your employer or its insurance carrier.

This employer IS [] IS NOT [] participating in a Managed Care Plan for medical care. The name of the Managed Care Plan is ______, its representative is ______, phone number ______.

DISABILITY BENEFITS to replace wages lost due to a workplace injury are payable under the Workers Compensation Act after seven (7) day of disability. A CLAIM MUST BE filed with the Department of Workers' Claim WITHIN TWO YEARS of the date of injury, or last payment of temporary total disability benefits.

NEED ASSISTANCE? Contact your employer's claim representative. If your questions about workers' compensation rights are not promptly answered call THE KENTUCKY DEPARTMENT OF WORKERS CLAIMS at 1-800-554-8601 to speak to an Ombudsman or Workers' Compensation Specialist.

EMPLOYER SUPERVISORS – NOTIFY MANAGEMENT IMMEDIATELY OF ALL INJURIES SO THAT TIMELY REPORT CAN BE MADE AS REQUIRED BY LAW.

04/09/09



ESTADO DE KENTUCKY

NOTIFICACIÓN REFERENTE A COMPENSACIÓN PARA TRABAJADORES (WORKERS COMPENSATION)

Los empleados de esta empresa están cubiertos bajo la Ley de Compensación para Trabajadores (*Workers Compensation Act*) del Estado de Kentucky (KRS Capítulo 342). A tenor de la ley imperante, esta Notificación tiene que ser colocada en un lugar visible.

Nombre del Empleador:		
Domicilio:		
Compañía del Seguro de Com (o administrador intermediario		
Núm. de Póliza:	, vigente desde	hasta
Domicilio:		
Teléfono:	Persona de Contacto:	

EMPLEADOS: Si se LESIONARA – NOTIFIQUE a su supervisor INMEDIATAMENTE, y si fuere posible, hágalo por escrito. EL INCUMPLIMIENTO DE ESTE REQUISITO podrá resultar en la denegación de los beneficios que le corresponden. OBTENGA ATENCIÓN MÉDICA. Su empleador tendrá que cubrir los gastos relacionados con toda la ATENCIÓN MÉDICA QUE FUERE NECESARIA para tratar una lesión sufrida en el lugar de trabajo. El empleado podrá elegir el médico o la instalación médica para su atención. Si el empleador participara en un Plan Aprobado de Atención Médica Coordinada (*Managed Care Plan*), el médico elegido por el empleado TENDRÁ QUE SER INTEGRANTE de la red aprobada de proveedores médicos (*approved provider network*) de dicho plan, salvo en el caso de ciertas emergencias. POR CONCEPTO DE LESIONES QUE REQUIERAN ATENCIÓN CONTINUA, el EMPLEADO TENDRÁ QUE DESIGNAR UN MÉDICO PARA LA DISPENSACIÓN DE SU TRATAMIENTO. Dicha designación tendrá que ser efectuada en el formulario que su empleador o la compañia de seguros le proporcione para este propósito.

Esta empresa SI participa NO participa en un Plan de Atención Médica Coordinada. El nombre del Plan de Atención Médica Coordinada es_____; su representante es

, teléfono

Los BENEFICIOS POR INCAPACIDAD, destinados a reemplazar el sueldo perdido como consecuencia de una lesión sufrida en el lugar de trabajo, serán pagados a tenor de la Ley de Compensación para Trabajadores después de siete (7) días de incapacidad. TODA RECLAMACIÓN TENDRÁ QUE SER presentada ante la Oficina de Reclamaciones de Trabajadores (*Office of Workers Claims*) DENTRO DE DOS AÑOS, contados a partir de la fecha de la lesión; o, por concepto de una incapacidad total temporal, DENTRO DE DOS AÑOS, contados a partir de la fecha del último pago de los beneficios correspondientes.

¿NECESITA ASISTENCIA? Comuníquese con el representante de reclamaciones de su empleador. Si sus preguntas referentes a los derechos para compensación laboral no fueren contestadas oportunamente, llame a la OFICINA DE RECLAMACIONES DE TRABAJADORES DEL ESTADO DE KENTUCKY marcando el 1-800-554-8601 y comuníquese con un Defensor (*Ombudsman*) o con uno de los Especialistas en Compensación para Trabajadores.

SUPERVISORES DEL EMPLEADOR – TODA LESIÓN SUFRIDA EN EL LUGAR DE TRABAJO TENDRÁ QUE SER REPORTADA INMEDIATAMENTE A LA GERENCIA CORRESPONDIENTE, PARA QUE LA MISMA PUEDA SER REPORTADA OPORTUNAMENTE, DE CONFORMIDAD CON LO REQUERIDO POR LEY.

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