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





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:

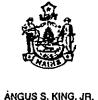
- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

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.



GOVERNOR

Workers' Compensation Board DEERING BUILDING AMHI COMPLEX 27 STATE HOUSE STATION AUGUSTA, MAINE 04333-0027

NOTICE

STATE OF MAINE

PAUL R. DIONNE EXECUTIVE DIRECTOR

December 31, 1998

Re:

Instructions for Completing the Employer's First Report of Occupational Injury or Disease, WCB-1 (10/98)

Dear Interested Party:

On October 20, 1998, the Board of Directors approved the revised First Report of Injury in order to collect claims performance data for the generation of Audit and Quarterly Compliance Reports

Effective January 1, 1999, the use of this form becomes mandatory.

This Notice provides instructions on the completion of the revised First Report of Injury.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE WCB-1 (10/98)

- A mandatory box means that the First Report will be returned to the employer and the insurer/TPA for completion. A claim will not be started in the Workers' Compensation Board (WCB) system.
- A required box means that a claim will be started in the Workers' Compensation Board system and a letter will be sent to the employer and the insurer/third-party administrator (TPA) indicating further information is required. The employer will have 14 days to correct the First Report previously sent with the information in the required boxes completed.
- All other boxes should be completed if the information is known.

REASON FOR REPORT SECTION

- It is mandatory that at least one box from 2(a) through 7(a) be check-marked.
- 2(a). If 2(a) is completed, then 2(b) is required.
- 5. If 5 is check-marked, then Date of Death is required.
- 6(a). If 6(a) is check-marked, then 6(b) and 6(c) should be completed.
- 7(a). If 7(a) is check-marked, then 7(b) and 7(c) should be completed.

EMPLOYER SECTION

- 8. Required.
- 9. Required.
- 10. Mandatory.
- 11. Required.
- 12. Required.
- 13. Required.
- 14. Required.
- 18. Required.



TDD: (207) 287-6119

INSURER, TPA, AND SELF-ADMINISTERED SECTION

| Ιt | is | req | uired | that | one | box | be | check | c-markec | l, |
|----|----|-----|-------|------|-----|-----|----|-------|----------|----|
|----|----|-----|-------|------|-----|-----|----|-------|----------|----|

☐ Insurer

□ TPA □ Self-administered

If the Insurer or TPA box is check-marked, then boxes 19, 22, 23, 24, and 25 are required.

If the Self-Administered Employer box is check-marked, then boxes 19 through 26 should be left blank.

EMPLOYEE SECTION

- 27. Mandatory.
- 28. Mandatory.
- 31. Required.
- 33. Required.
- 34. Required.
- 35. Required.
- 36. Required.
- 37. Required.
- 41. Required.

CLAIM INFORMATION SECTION

- 42. Mandatory.
- 43. Mandatory if boxes 2(a) and 2(b) are check-marked.
- 44. Required.
- 45. Required if the Insurer or TPA box is check-marked. Not required if Self-administered Employer box is check-marked.
- 46. Required.
- 47. Required if 2(a) is check-marked and, if Yes, then the date is required.
- 48. Required.
- 49. Required.
- 52. Required.

PREPARER INFORMATION SECTION

57. Required.

Please contact me if you have any questions.

Sincerely,

Steve Minkowsky

Deputy Director of Benefits Administration

SM/amp

cc: Paul R. Dionne

Executive Director

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

| REASON FOR REPORT (check all that apply) | | | | | | | | | | | | | | |
|--|---|---|----------------------------|--|--------------------|------------------------------------|---|--|---|---|---------------------------------------|--|--|--|
| 2a. LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? 3. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 5. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 5. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 5. LOST EARNINGS BUT NO LOST TIME 5. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 4. LOST EARNINGS BUT NO LOST TIME 5. LOST EARNINGS BUT NO LOST TIME 5. LOST EARNINGS BUT NO LOST TIME 6. LOST EARNINGS BUT NO LOST TIME 7. LOST EARNINGS BUT NO LOST TIME 8. LOST EARNINGS BUT NO LOST TIME 9. LOST EARNINGS BUT NO LOST TIME 10. LOST EARN | | | | | | | | | | | | | | |
| 6a, OCCUPATIONAL DISEASE | | | | | | | | | | | | | | |
| 7a. CORRECT PRIOR REPORT | MM DD YYYY / / / / / / / / / / / / / / / / / | | | | | | | | | | | | | |
| 8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): | 9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): | | | | | | | 10. EMPLOYER NAME: | | | | | | |
| 11. STREET/P.O BOX MAILING ADDRESS: | | 12. CITY: | 13. ST | TATE: | 10 | 14. ZIP: 15. TELEPHONE NUMBER: () | | | | | | | | |
| 16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: | | 17. EMPLOYER LOCATION MAILING ADDRESS: | \$ | | | | CCUR ON EMPLOYER'S PREMISES? YES NO YSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS | | | | | | | |
| (check one) I INSURER | | □ πiii | RD PARTY | ADMINIST | RAT | OR (TPA) | | E | SELF-A | DMINISTERED EMPLO | YER | | | |
| 19. INSURANCE / TPA COMPANY NAME: | 2 | O. POLICY NUMBER: | | | | | | 11. INSUF | RER FILE NU | MBER: | | | | |
| 22, STREET/P.O. BOX MAILING ADDRESS: | 2: | 3. CITY: | | | 24. S | TATE: | 2 | 25. ZIP; | | 26. TELEPHONE NUMBER | ₹ | | | |
| | | | | EMP | LOY | ΈE | | | | | | | | |
| 27. LAST NAME: | 28, FIRST NAME: 29, MI: | | | 30. TELEPHONE NUMBE () | | | | 31. SOCIAL | . SECURITY NUMBER: -XX- | 32. GENDER: ☐ MALE ☐ FEMALE | | | | |
| 33. STREET/P.O. BOX MAILING ADDRESS: | 3 | 34. CITY: | | | 35. STATE: | | | 36. ZIP: 37. DATE OF | | | | | | |
| 38. OCCUPATION/JOB TITLE: | | 39. DATE OF HIRE: 40. WEEKLY WAGE \$ | | | AY TIME OF INJURY: | | | 41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? LYES NO IF YES, GIVE NAME AND ADDRESS: | | | | | | |
| | | | | CLAIM IN | FOR | MATION | | | | | | | | |
| | J. | E OF INCAPACITY: | 1 | EMPLOYER 30 a.m.): | BEG | SAN WORK | _ | | | NOTIFIED INSURER/TPA: | | | | |
| | | ND YYYY MPLOYER NOTIFIED: | 46. TIME C | 46. TIME OF INJURY (e.g. 1:10 p.m.): | | | | | MM DD YYYY 47, HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO | | | | | |
| | | | | | | | | | IF YES, GIVE DATE:/ | | | | | |
| NUM DD YYYY | | D YYYY | | | | | | |). ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS | | | | | |
| 48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): | 49. | BODY PART(s) AFFECTED (e | | • | | | USING | WHEN TI | HE EVENT C | CCURRED (e.g. acetylene to | orch, metal płate): | | | |
| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS EN OCCURRED (e.g. cutting metal plate for flooring.): | THAT D | 52. HOW INJURY OR ILLNESS OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g., worker stepped back to inspect work and stopped on some scrap metal. As worker fell, worker brushed against hot metal.): | | | | | | | | | | | | |
| WAS ACTIVITY PART OF NORMAL JOB DUTIES? | | | | | | | | | | | | | | |
| 53. HOSPITALIZED OVERNIGHT AS INPATIENT? S4. WAS THE EMPLOYEE TREATES. HEAD IN AN EMERGENCY ROOM? YES NO: | | | HEALTH CARE | ALTH CARE PROVICER NAME: 56. MAILING ADD | | | | | | 57. TELEPHONE NUMBER: () | | | | |
| | | L | P | REPARER | INFO | ORMATION | | | | | | | | |
| 58. PREPARER NAME AND TITLE (TYPE OR PRI | | ephone nu) | in the second | (() for a solution and an array of the solution of the solutio | | | 60. DATE SENT TO WCB: MM DD YYYY | | | | | | | |
| THE STATE OF MAINE DOES NOT DISCRIM THIS FORM IS AVAILABLE IN ALTERNATIVE OR TITY Mains Relay 711. | IINATE E FORM | ON THE BASIS OF DISAB NAT. FOR FURTHER ASSIS | ILITY IN ADA STANCE, CO | MISSION TO INTACT TH |), AC E MA | CESS TO, OR OF INE WORKERS | PERATIO COMPE | ON OF I | TS PROGR IN BOARD, | AMS, SERVICES, OR AC ADA COORDINATOR, TI | TIVITIES. ELEPHONE: 1-888-801-9087 | | | |

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1a. OSHA 300 CASE NUMBER (if applicable):

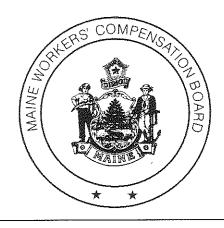
| | | | REASON F | OR REPOR | eT (c | heck all that apply | | | | | | | |
|---|--|--|--|--|---|--|----------------------------|---|--|-------------------------------------|--|--|--|
| 2a. LOST TIME - ONE OR MORE DAYS 2 3. LOST EARNINGS BUT NO LOST TIME | LOST TIME - ONE OR MORE DAYS 26. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? LOST EARNINGS BUT NO LOST TIME 4. MEDICAL/HEALTH CARE Description: Medical/Health Care Description: Desc | | | | | | | | | | | | |
| 6a. OCCUPATIONAL DISEASE | | 6b. DATE OF LAST EXPO | | | | | | | | | | | |
| 7a. □ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: | | | | | | | | | | | | | |
| | | | | | 100000 | YER | | | | | | | |
| 8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): | | 9. FEDERAL EMPLOYER | R IDENTIFICA | TION NUMBER | ₹(FE | .(N): | 10. EMP | PLOYER NAME | <u>:</u> | | | | |
| 11. STREET/P.O BOX MAILING ADDRESS: | | 12. CITY: | | | | .STATE: | 14. ZIP: | | 15. TELEPHONE NUMBER | Ċ. | | | |
| 16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED; | | 17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: | | | | | AME AND PHY | | I PLOYER'S PREMISES? U Y ESS OF THE EMPLOYER WH | YES □ NO HERE THE EMPLOYEE WAS | | | |
| (check one) I INSURER | | | HIRD PART | TY ADMINIS | TR/ | TOR (TPA) | | SELF-/ | ADMINISTERED EMPLO | IVER | | | |
| 19. INSURANCE / TPA COMPANY NAME: | | 20. POLICY NUMBER: | William Communication of | <u> Marikatikan mu</u> | distance | | www.commontenance. | URER FILE NU | | <u> </u> | | | |
| 22. STREET/P.O. BOX MAILING ADDRESS: | | 23. CITY: | | | 24. | STATE: | 25. ZIP: | | 26. TELEPHONE NUMBER | Ŀ | | | |
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| 27, LAST NAME: | | 28. FIRST NAME: | 1997 (The State of the State of | 29. MI: | | 30. TELEPHONE NUM () | | xxx- | L SECURITY NUMBER: | 32. GENOER: MALE FEMALE | | | |
| 33. STREET/P.O. BOX MAILING ADDRESS: | | 34. CITY: | | | | 35. STATE: | 36. ZIP: | | 37. DATE OF BIRTH: / / / MM DD YYYY | | | | |
| 38. OCCUPATION/JOB TITLE: | | 39. DATE OF HIRE: 40. WEEKLY WAGE | | | | | · | 41. DOËS EMPLOYEE WORK FOR ANOTHER EMPLOYER? YES NO IF YES, GIVE NAME AND ADDRESS: | | | | | |
| 42. DATE OF INJURY OR ILLNESS: | - 42 DA | TE OF INCAPACITY: | I 44 T | CONTRACTOR OF THE PARTY OF THE | 200000000000000000000000000000000000000 | RMATION | I SE DAT | - CUD OVER | WATER TOURTH TO | | | | |
| | | <u> </u> | | TIME EMPLOYE . 7:30 a.m.): | Æ BE | EGAN WURK | | | R NOTIFIED INSURER/TPA: | | | | |
| NUI DO YYYY | | DD YYYY | 46. TIN | MM DD YYY 16. TIME OF INJURY (e.g. 1:10 p.m.): 47. HAS EMPLOYE | | | | | ETURNED TO WORK? 🔲 YE | FS □ NO | | | |
| DATE EMPLOYER NOTIFIEO: | J. | EMPLOYER NOTIFIED: | | | | | | GIVE DATE: | | | | | |
| MM DD YYYY | | DO YYYY | | | | | | | NUM DD YYYY | | | | |
| 48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatits); | | 9. BODY PART(s) AFFECTED | , , | • . | | Ü | JSING WHEN T | THE EVENT O | RIALS, OR CHEMICALS EMP DCCURRED (e.g. acetylene to | orch, metał płate): | | | |
| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS E OCCURRED (e.g. cutting metal plate for flooring.) | THAT | 52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hol metal.): | | | | | | | | | | | |
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| 53. HOSPITALIZED OVERNICHT AS INPATIENT? U YES U NO | NAN | VAS THE EMPLOYEE TREATES: I EMERGENCY ROOM? VES III NO: | 5. HEALTH CAR | RE PROVICER N | (AME | 56. MAJLING ADDR | ESS: | | 57. TELEPHONE NU | JMBER: | | | |
| | | | riche riche Amerikan ber | Control of the Contro | | FORMATION | | | | | | | |
| 58. PREPARER NAME AND TITLE (TYPE OR PR | • | | (| ELEPHONE NU) | | | | | 60. DATE SENT TO WCB: | MM DD YYYY | | | |
| THE STATE OF MAINE DOES NOT DISCRITHIS FORM IS AVAILABLE IN ALTERNATIVOR TTY Maine Relay 711. WCR.16ff 10193 | MINATE VE FOR | ON THE BASIS OF DISA MAT. FOR FURTHER AS: | BILITY IN A | DMISSION TO CONTACT TH | Ö, AI IE M | CCESS TO, OR OPEI IAINE WORKERS' CC | RATION OF D DMPENSATION | ITS PROGRA ON BOARD, | AMS, SERVICES, OR ACT ADA COORDINATOR, TE | IVITIES. LEPHONE: 1-888-801-9087 | | | |

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (frapp@cable):

| | 555 TX 556 | | 610-65-0 1950AC451 | nomen et la compete de | 02440 | some state allowable and | a contractor | Self-tervensoren | | NEW STREET | XISSANISSA KARISA KARI | | | |
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| 2a. ☐ LOST TIME - ONE OR MORE DAYS | 2b. W | _ | | ON DAY OF IN | IJURY | | | □ но | | | | | | |
| 3. LOST EARNINGS BUT NO LOST TIME | | 4. MEDICALHEAL | | | | | | | OF DEATH: | MM DD Y | | | | |
| 6a. ☐ OCCUPATIONAL DISEASE | | 6b. DATE OF LAST EXP | | DD YYYY | | 6c. DATE OF | DIAGNO | SA SISC | OCCUPATIO | WALLY RELAT | ed:/_ MM od | _ | | |
| 7a. CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: | | | | | | | | | | | | | | |
| | | | | EMP | LOY | ER | | | 471 | | | | | |
| 8, STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): | R IDENTIFICATION | ENTIFICATION NUMBER (FEIN): | | | | | 10. EMPLOYER NAME: | | | | | | | |
| 11. STREET/P.O BOX MAILING ADDRESS: | | | 13.81 | TATE: | | 14. ZIP: | | 15. TELEPH(| ONE NUMBER | R: | | | | |
| 16. PRIMARY BUSINESS PERFORMED BY | | 17. EMPLOYER LOCAT | ION IF DIFFEREN | YT FROM | 1 | O VOITIUM PIO PO | EYBOR | I IDE OC | ^110 AN C116 | N OVED'S BOE | пиесезПу | VES THO | | |
| EMPLOYER WHERE INJURY OCCURRED: | | 10. DID INJURY ON EXPOSURE OCCUR ON E | | | | | | RESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS | | | | | | |
| (check one) L INSURER | to the | _, | HIRD PARTY | ADMINIST | PAT | OR (TPA) | | F | T SELEJ | MINISTER | ED EMPLO | IVED | | |
| 19. INSURANCE / TPA COMPANY NAME: | | 20. POLICY NUMBER: | | | an Kada | | | X258 11 1874 | RER FILE NU | STOPPONE ZAHET MARK | | | | |
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| 22. STREET/P.O. BOX MAILING ADDRESS: | | 23. CITY: | | | 24. S | TATE: | | 25. ZiP: | | 26. TELEPHO | ONE NUMBER | ₹ : | | |
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| 27. LAST NAME: | | 28. FIRST NAME: | | 29. MI: | | O. TELEPHONE N | UMBER: | | 31. SOCIAL | L SECURITY N | UMBER: | 32. GENDER: | | |
| | | | | | 1 | () | | | | · vv | | ☐ MALE ☐ FEMALE | | |
| 33, STREET/P.O. BOX MAILING ADDRESS: | | 34. CITY: | | <u> </u> | ٠, | OF OTLE | | XXX-XX | | | OF BIRTH: | | | |
| 33, STREETIF O. BOX MAILING ADDRESS, | | 34. GITT. | | | 35. STATE: | | 36. ZiP: | | | 37. DATE | OF BIKIN: | | | |
| | | | | | | | | | | MM DD YYYY | | | | |
| 38. OCCUPATION/JOB TITLE: | - | 39. DATE OF HIRE: 40. WEEKLY WAGE | | | | HE OF INJURY: | | 41. DOES | S EMPLOYER | WORK FOR ANOTHER EMPLOYER? | | | | |
| | | , , | | | | | ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS: | | | | | | | |
| | | MM DO YYYY | Ť | \$ | | | | | | | | | | |
| | | | | CLAIM IN | 100 - 100 p | | | | | | | | | |
| 42. DATE OF INJURY OR ILLNESS: | 43. D. | ATE OF INCAPACITY: | | E EMPLOYEE | BEG | AN WORK | - 1 | 45. DATE | EMPLOYER | R NOTIFIED INS | URER/TPA: | | | |
| | | <u></u> | (8.9.1) | (e.g. 7:30 a.m.): | | | | | | | | | | |
| MM DD YYYY | ММ | DD YYYY | 40 TIME | (0 TIME OF IN BIDY (0 a 440 a m)) | | | | | MM DD YYYY | | | | | |
| DATE EMPLOYER NOTIFIED: | DATE | EMPLOYER NOTIFIED: | 40. IM | 48. TIME OF INJURY (e.g. 1:10 p.m.): | | | | | 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO | | | | | |
| | | 11_ | | | | | | | IF YES, GIVE DATE: | | | | | |
| JULI DD YYYY | ММ | DD YYYY | | | | | | | | MM OD Y | ΥΥΥ | | | |
| 48. SPECIFIC INJURY OR ILLNESS | | 49. BODY PART(s) AFFECTE | D (e.g. lower right | forearm): | | | | | | RIALS, OR CHE | | | | |
| (e.g. second degree burn or loxic hepatits); | | | | | | | USING | WHEN I | HE EVENT C | XXXURRED (e.ç | g. acely/ene to | orch, metal plate): | | |
| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS OCCURRED (e.g. cutting metal plate for flooring. | THAT D | 52. HOW INJURY OR ILLNESS OCCURRED, DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g., worker stepped back to inspect work and supped on some scrap metal. As worker fell, worker brushed against hot metal.): | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | |
| WAS ACTIVITY PART OF NORMAL JOB DUTIE | s? 🗖 Y | yes 🗖 no | | | | | | | | | | | | |
| 53. HOSPITALIZED OVERNIGHT AS INPATIENT? | | WAS THE EMPLOYEE TREATE | 55. HEALTH CARE | PROVICER NA | WE | 56. MAILING AD | DRESS: | | | 57. TE | LEPHONE N | UMBER: | | |
| ☐ YES ☐ NO NAN EMERGENCY ROOM? ☐ YES ☐ NO: | | | | | | | | | | (|) | | | |
| | 15 (2) | | P | REPARER | INFC | RMATION | | | | l l | | | | |
| 58. PREPARER NAME AND TITLE (TYPE OR P | RINT): | | | EPHONE NUI | ~ X | MANAGEMENT TO STORY STREET, SHARE | | 2,000,000 | | 60. DATE SE | NT TO WCB: | | | |
| | | | (|) | | | | | | | | MM DD YYYY | | |
| THE STATE OF MAINE DOES NOT DISCR | MINA | TE ON THE BASIS OF DIS | ARILITY IN ADI | MISSION TO | , AC | CESS TO OR OF | PERATI | ON OF I | TS PROGP | AMS SERVIC | CES OR AC | | | |
| THIS FORM IS AVAILABLE IN ALTERNATI OR TTY Maine Relay 711. | | | | | | | | | | | | | | |
| WCB-1 (eff. 1/1/13) | | | | | | | | | | | | | | |



WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

AUGUSTA

24 Stone Street, Suite 102 Augusta, ME 04330 207-287-2308 1-800-400-6854

LEWISTON

36 Mollison Way Lewiston, ME 04240-5811 207-753-7700 1-800-400-6857

BANGOR

106 Hogan Road, Suite 1 Bangor, ME 04401 207-941-4550 1-800-400-6856

PORTLAND

62 Elm Street Portland, ME 04101 207-822-0840 1-800-400-6858

CARIBOU

43 Hatch Drive, Suite 110 Caribou, ME 04736-2347 207-498-6428 1-800-400-6855

Visit our website at: www.maine.gov/wcb Statewide TTY: 1-877-832-5525

Notice to Employees:

State law requires your employer to provide workers' compensation insurance for its employees. Workers' compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 90 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

It is against the law for employers to misclassify employees as independent contractors for the purposes of avoiding workers' compensation insurance, unemployment coverage, or other employer paid taxes and withholdings. For more information on laws pertaining to the hiring of independent contractors, visit the Worker Misclassification Task Force website at www.maine.gov/labor/misclass.

If you have any questions about your rights, please contact one of the regional offices.

A l'intention desEmployes:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVENEZ VOTRE EMPLOYEUR IMMEDI-ATEMENT. Passé un délai de 90 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers'Compensation Board met des conseillers juridiques à leur disposition.

La loi interdit aux employeurs de classifier fallacieusement leurs salariés comme étant des contractants privés aux fins d'échapper a l'assurance compensatrice-employé, aux

indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative a l'utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés): www.maine.gov/labor/misclass.

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFÍQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 90 días. Así mismo esta reclamación debe hacer referencia a unaccidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

El hecho de no clasificar a los empleados como contratistas independientes, con el propósito de evitar el seguro por compensación al trabajador, cobertura para desempleados, ú otros impuestos pagados y retenidos por el empleador; está en contra de la ley del empleador. Para mayor información acerca de las leyes pertenecientes a la contratación de contratistas independientes, visite el Worker Misclassification Task Force en la página web de www.maine.gov/labor/misclass.

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

Interpreters Available

When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

Tenemos intérpretes a su disposición

Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

Temos intérpretes à sua disposição

Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

Abbiamo interpreti disponibili

Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un intèrprete sará messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

Des interprètes sont à votre disposition

Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne. Tłumacze dostępni na życzenie.

Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linii.

"К вашим услугам имеются переводчики"

"Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите "РАШН"); и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии."

提供口譯服務

打電話請求幫助時,請用英語說"挟音呢斯" (CHINESE)— 我們將為您提供口譯人員。請不 要挂斷電話。

通訳サービスをご利用いただけます

通訳を必要とされる場合は「ジャパニーズ」と おっしゃり、通訳がでるまでそのままでお待ちく ださい。

한국어 통역을 이용하실 수 있습니다.

도움이 필요하여 전화를 거실 때 영어로 코라언 Q (KOREAN)이라고 말씀하시면 통 역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오. "Có Thông Dịch Viên"

"Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói "VIETNAMESE" để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.

مترجمون شفهيون متيسّرون لخدمتكم عند اِتَصالكم للمساعدة أو لطلب خدمة معيّنة نرجو منكم أن تذكروا

افراد مترجم در دسترس مي باشند.
را كه بدان صحبت مي كنيد به انگليسي ذكر كنيد تا
راجع به امري به ما تلفن مي كنيد، لطفا نام زياني
قطع نكنيد. هنگاميكه براي درخواست كمك يا
شما تماس گرفته شود. لطفا روي خط منتظر بمانيد.

Turjunaanno waa la helayaa

Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Taleefoonkana ha dhigin.

To the employer: This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities.

This poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY (877) 832-5525.