

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.

WORKERS' COMPENSATION COMMISSION
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**PURSUANT TO COMAR 14.09.01.10 REQUIRING THE DISCLOSURE OF
MEDICAL INFORMATION IN A WORKERS' COMPENSATION CLAIM**

TO: _____
(Name of Record Holder)

PATIENT/CLAIMANT NAME:	SS#:	DATE OF BIRTH:	DATE OF ACCIDENT:

I, hereby, authorize you to give to:

(Name of Record Requestor)

a copy of all information developed by you in my medical record regarding the condition of the following part or parts of my body or my medical condition:

(Specify part or parts of body or medical condition.)

while under your observation or treatment or otherwise in your possession. This includes, but is not limited to, history, findings, office and patient charts and files, examination and progress notes, physical evidence prepared by you and any subsequent or future developments relating to my health or mental condition. ***This authorization is valid for up to one year from the date it is signed. I understand that I may revoke this authorization in writing at any time.***

Disclosure of medical information pursuant to this authorization is **NOT** prohibited under the **Health Insurance Portability and Accessibility Act** ("HIPAA").

The Health Insurance Portability and Accessibility Act ("HIPAA") at 45 CFR sect. 164.512 provides: "a covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault."

SIGNATURE of claimant/patient or authorized representative

DATE

10 East Baltimore Street • Baltimore, Maryland 21202-1641
410-864-5100 • Email: info@wcc.state.md.us • Web: <http://www.wcc.state.md.us>

WORKERS' COMPENSATION COMMISSION

REQUEST FOR MODIFICATION

INSTRUCTIONS: This form is to be used by parties to a compensation claim only to request that an Order be reconsidered, reopened or modified pursuant to LE §9-736. Fill out this form completely and submit to the Commission without a cover letter. This form must be accompanied by Issues (WCC Form H24R).

CLAIM NUMBER: _____ CLAIMANT: _____

EMPLOYER: _____

INSURER: _____

The undersigned party to this Workers' Compensation Claim hereby requests modification of the Order dated _____ and as justification states:

- The claimant is entitled to additional temporary total benefits.
The claimant's permanent disability has increased.
The claimant's permanent disability has decreased.
Other

REQUESTED BY:

FULL NAME STREET ADDRESS

CITY STATE ZIP CODE

- CLAIMANT CLAIMANT'S ATTORNEY EMPLOYER/INSURER
EMPLOYER/INSURER'S ATTORNEY OTHER

A copy of this form with supporting documentation, including Issues (H24R), has been sent to the other parties/attorneys to this action.

SIGNATURE

DATE

PHONE NUMBER

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS UNLESS APPROPRIATE

DATES:

Enter all dates in MM/DD/YY format. Enter all time in HH:MM format (e.g. 06:05)

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	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	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:

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.

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 LA COMPENSACIÓN DEL TRABAJADOR

in en Maryland

Job Related Accidental Personal Injury or Occupational Disease?

If you are disabled and unable to work for more than three (3) days, your employer's workers' compensation insurance company may pay your medical bills and other expenses and replace two-thirds (2/3) of your salary (limited to the maximum set by law).

If you are injured on the job:

1. Notify your employer or supervisor at once. You cannot receive full benefits unless your employer knows you are injured.
2. Tell the doctor who treats you that you were hurt on the job.
3. Complete an Employee's Claim Form C-1 (available by phone or on the Commission's website) and send it to us as soon as possible.

Note: Withholding information or giving false information about any work-related activity or return to work could prevent you from receiving benefits and may subject you to fines, imprisonment or both.

¿Accidentes por lesión/daño corporal relacionados con el Empleo o Enfermedad Profesional?

Si usted se encuentra incapacitado o inhabilitado para trabajar por más de tres días, el seguro de trabajadores que tienen las compañías pudiera cubrir las facturas médicas y otros gastos relacionados. También le compensarían 2/3 de sus ingresos (Hasta un monto máximo estipulado por la ley).

Si usted sufre una lesión en el trabajo, debe:

1. Informarle a su empleador o supervisor de inmediato. No podría recibir todos sus beneficios a menos que su empleador fuere notificado que sufrió una lesión.
2. Informarle al médico quien le administre tratamiento que usted se lesionó en su trabajo.
3. Llenar el formulario Employee's Claim Form C-1 (disponible consultando la página del Internet para el Workers' Compensation o solicitándolo uno por teléfono). Diligenciarlo para que las oficinas del Workers' Compensation lo reciban lo antes posible.

Aviso: El suministrar información falsa u ocultar información sobre cualquier actividad relacionada con su trabajo o relacionada con su regreso al trabajo, pudiera afectar los beneficios que recibiera o pudiera acarrearle multas, encarcelamiento o ambas.

Employer/Empleador

Business Address/Dirección

City/State/Zip

Ciudad/Estado/Código Postal

Federal Employer ID (FEIN)

Identificación Federal Del Empleador

Telephone Number/Número Telefónico

Insurance Company Name

La Compañía de Seguro

Insurance Company Telephone

Telefónico de la Compañía de Seguro

MD WCC Form C-24 11/2007

Maryland Workers' Compensation Commission

10 East Baltimore Street, Baltimore, Maryland 21202-1641

(410) 864-5100 / Outside Baltimore (800) 492-0479

Webpage - <http://www.wcc.state.md.us> / TTY Users - 711 in Maryland or (800) 735-2258

This notice must be printed on 8.5" X 14" gold or yellow paper, display complete employer information and be posted in a conspicuous location at each work site or location in accordance with COMAR 14.09.01.02 and 14.09.01.03.