

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.



The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
 1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
 Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
 http://www.mass.gov/dia

DIA USE ONLY

Print Form

EMPLOYER'S FIRST REPORT OF INJURY
OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.

INSTRUCTIONS AND CODES ON THE REVERSE SIDE - Please Print Legibly or Type - Unreadable forms will be returned.

EMPLOYEE	1. Employee's Name (Last, First, MI):		2. Home Telephone Number:	3. Social Security Number*:	4. Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
	5. Home Address (No., Street, City, State & Zip Code):			5a. Native Language Code: _____ Other: _____	6. Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S	7. No. of Dependents:
	8. Date of Hire (mm/dd/yyyy):		9. Date of Birth (mm/dd/yyyy):		10. Average Weekly Wage: \$ _____ <input type="checkbox"/> Estimated <input type="checkbox"/> Actual	
EMPLOYER	11. Employer's Name:			12. Federal Tax I.D. Number:		
	13. Employer's Address (No., Street, City, State & Zip Code):			14. Employer's Telephone Number:		
	15. Industry Code (See Reverse Side):			16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):		
	17. W.C. Policy Number:			18. Self-Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Self-Insurer Number: _____		
INFORMATION	19. Business Type : <input type="checkbox"/> Service <input type="checkbox"/> Wholesale <input type="checkbox"/> Mfg. <input type="checkbox"/> Retail <input type="checkbox"/> Other _____			20a. Insurer's Case/Claim File No.:		
	20. DATE OF INJURY (mm/dd/yyyy):			21. Was Employee Injured on Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	22. Location of Injury if not on Employer's Premises:			23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):		
	24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):			25. If Employee has Died, Date of Death (mm/dd/yyyy):		
	26. Source of Injury (Chemicals, Machinery, etc.):			27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:		
	28. Person to Whom Injury was Reported (list position):		29. Date Reported (mm/dd/yyyy):		30. Date Reported as work related (mm/dd/yyyy):	
	31. Injury Code(s) _____ Body Part Code(s) _____ a. _____ to body part a. b. _____ to body part b. c. _____ to body part c.		32. Witness(es) to Injury - Give Full Name(s), if none state as such:			
	33. Has Employee Returned to Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		34. Date Employee Returned to Work(mm/dd/yyyy):			
35. Employee's Regular Occupation:		36. Has Employee Returned to Regular Occupation: <input type="checkbox"/> Yes <input type="checkbox"/> No				
PREPARER	37. PREPARER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):			38. PREPARER'S Title:		
	39. PREPARER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):		40. Date Prepared (mm/dd/yyyy):		40a. PREPARER'S e-mail address:	

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your report.

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

**EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY
FILING INSTRUCTIONS**

1. **WHEN TO FILE:** File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.
2. **WHERE TO FILE:** This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.
3. **PENALTIES:** Failure to report injuries on this form may result in a fine of \$100.00 in accordance with M.G.L. Chapter 152, Section 6.
4. **EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39:** This form must be filed by the employer or an authorized agent/representative of the employer.

NATIVE LANGUAGE CODES

1 – English / 2 – Portuguese / 3 – Haitian Creole / 4 – Spanish / 5 – Chinese / 6 – Vietnamese / 7 – Cape Verdean / 9 – Other

INDUSTRY CODES

<u>Agriculture, Forestry and Fishing</u> 01 Agriculture Production - Crops 02 Agriculture Production - Livestock 07 Agricultural Services 08 Forestry 09 Fishing, Hunting and Trapping	<u>Chemicals and Allied Products</u> 28 Chemicals and Allied Products 29 Petroleum and Coal Products 30 Rubber and Misc. Plastic Products 31 Leather and Leather Products 32 Stone, Clay and Glass Products 33 Primary Metal Industries 34 Fabricated Metal Products 35 Industrial Machinery and Equipment 36 Electronic and Other Electrical Equipment 37 Transportation Equipment 38 Instruments and Related Products 39 Miscellaneous Manufacturing Industries	<u>Wholesale Trade - Non-durable Goods</u> 51 Wholesale Trade - Non-durable Goods	<u>Motion Pictures</u> 78 Motion Pictures 79 Amusements and Recreation Services 80 Health Services 81 Legal Services 82 Educational Services 83 Social Services 84 Museums, Botanical, Zoological Gardens 86 Membership Organizations 87 Engineering and Management Services 88 Private Households 89 Services, NEC
<u>Mining</u> 10 Metal Mining 12 Coal Mining 13 Oil and Natural Gas 14 Nonmetallic Minerals, Except Fuels	<u>Transportation and Public Utilities</u> 40 Railroad Transportation 41 Local and Interurban Passenger Transit 42 Trucking and Warehousing 43 U.S. Postal Service 44 Water Transportation 45 Transportation by Air 46 Pipelines, Except Natural Gas 47 Transportation Services 48 Communications 49 Electric, Gas and Sanitary Services	<u>Retail Trade</u> 52 Building Materials and Garden Supplies 53 General Merchandizing 54 Food Stores 55 Automotive Dealers and Service Stations 56 Apparel and Accessory Stores 57 Furniture and Home Furnishing Stores 58 Eating and Drinking Establishments 59 Miscellaneous Retail	<u>Finance, Insurance and Real Estate</u> 60 Depository Institutions 61 Non-depository Institutions 62 Security and Commodity Brokers 63 Insurance Carriers 64 Insurance Agents, Brokers and Service 65 Real Estate 67 Holding and Other Investment Officers
<u>Construction</u> 15 General Building Contractors 16 Heavy Construction, Ex. Building 17 Special Trade Contractors	<u>Wholesale Trade</u> 50 Wholesale Trade - Durable Goods	<u>Services</u> 70 Hotels and Other Lodging Places 72 Personal Services 73 Business Services 75 Auto Repair Services and Parking 76 Miscellaneous Repair Services	<u>Public Administration</u> 91 Executive, Legislative and Garden 92 Justice, Public Order, and Safety 93 Finance, Taxation, and Monetary Benefits 94 Administration of Human Services 95 Environmental Quality and Housing 96 Administration of Economic Program 97 National Security and International Affairs
<u>Manufacturing</u> 20 Food and Kindred Products 21 Tobacco Products 22 Textile Mill Products 23 Apparel and Other Textile Products 24 Lumber and Wood Products 25 Furniture and Fixtures 26 Paper and Allied Products 27 Printing and Publishing			<u>Non-classifiable Establishments</u> 99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Erucloation 110 Asphyxia or Strangulation Etc. 120 Burns (Heat) 130 Burns (Chemical) 140 Concussion 160 Contusion, Crushing, Bruise 170 Cut, Laceration, Puncture 190 Laceration 200 Electric Shock, Electrocution 210 Fracture 250 Hernia, Rupture 300 Scratches, Abrasions 310 Sprains, Strains 400 Multiple Injuries 900 No Injury 950 Damage to Prosthetic Devices 995 No Other Injury, NEC** 999 Non-classifiable	157 Tuberculosis 159 Other Infective or Parasitic Diseases <u>Dermatitis</u> 180 Dermatitis, UNS* 183 Primary Infections of the Skin 184 Other Skin Conditions 185 Dermatitis, Allergic or Contact 189 Skin Condition, NEC** <u>Poisoning Systemic</u> 270 Poisoning, Systemic, UNS* 271 Due to Toxic Materials other than Lead 272 Diseases of the Blood and Blood Forming Organs 273 Upper Respiratory Conditions 274 Influenza, Pneumonia, Etc. 276 Other Diseases of the Gastro-Intestinal Tract 278 Effects of Lead 279 Other Toxic Effects of One System Only <u>Respiratory Systems, Conditions of</u> 570 Respiratory Systems, Conditions of 571 Upper Respiratory 572 Asthma, Influenza, Pneumonia <u>Pneumoconiosis</u> 280 Pneumoconiosis	281 Aluminosis 282 Anthracosis 283 Asbestosis 284 Bysinosis 285 Siderosis 286 Silicosis 287 Other Pneumoconioses 289 Pneumoconiosis and Tuberculosis <u>Nervous System, Conditions of</u> 560 Nervous System, Conditions of - NEC** 561 Diseases of the Central Nervous System 562 Diseases of the Nerves and Peripheral Ganglia <u>Neoplasm Tumor</u> 550 Neoplasm Tumor, UNS* 551 Malignant 552 Benign <u>Radiation Effects</u> 290 Radiation Effects, UNS* 291 Non-Ionizing Radiation 292 Microwaves 293 Ionizing Radiation - X-Ray 294 Ionizing Radiation - Isotopes 295 Welder's Flash	<u>Other</u> 265 Carpal Tunnel Syndrome 510 Cardiovascular and Other Conditions of the Circulatory System 520 Complications Peculiar to Medical Care 500 Effects of Changes in Atmospheric Pressure 240 Effects of Environmental Heat 220 Effects of Exposure to Low Temperature 530 Eye, other Diseases of the Eye 230 Hearing Loss or Impairment 991 Heart Condition, Excludes Heart Attack 320 Hemorrhoids 330 Hepatitis, Serum and Infective 275 Hepatitis, Toxic 260 Inflammation of Joints, Etc. 540 Mental Disorders 900 No Illness 999 Non-classifiable 990 Occupational Disease, NEC** 580 Symptoms and ill-defined Conditions
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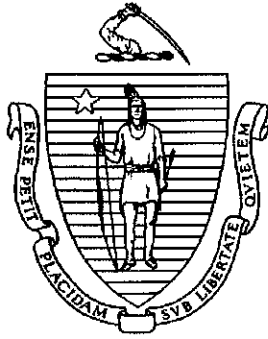
BODY PART AFFECTED CODES

<u>Head</u> 100 Head, UNS* 110 Brain 120 Ear(s), UNS* 121 Ear(s), External 124 Ear(s), Internal 130 Eye(s), UNS* 140 Face, UNS* 141 Jaw, Chin 144 Mouth and Throat (vocal chords, larynx) 146 Nose 148 Face, Multiple Parts 149 Face, NEC** 150 Scalp	160 Skull 198 Head Multiple 200 Neck & Cervical Vertebrae <u>UPPER EXTREMITIES</u> 300 Upper Extremities, NEC** 310 Arm(s), UNS* 311 Upper Arm 313 Elbow(s) 315 Forearm(s) 318 Arm(s), Multiple 319 Arm(s), NEC** 320 Wrist(s) 330 Hand(s), Not Wrists or Fingers 340 Finger(s)	398 Upper Extremities, Multiple 400 Trunk, UNS* 410 Abdomen, Internal Organs, Inguinal Hernia 420 Back 430 Chest, Ribs, Breastbone, Internal Organs 440 Hip(s)...Pelvis, Organs and Buttocks 450 Shoulder(s) 498 Trunk, Multiple <u>LOWER EXTREMITIES</u> 500 Lower Extremities 510 Leg(s), UNS*	513 Knee(s) 515 Lower Leg(s) 518 Leg(s), Multiple 519 Leg(s), NEC** 520 Ankle(s) 530 Foot or Feet, Not Ankle 540 Toe(s) 598 Lower Extremities, Multiple 700 MULTIPLE PARTS Applies when more than one major body part as been effected such as an arm and a leg 999 NON-CLASSIFIABLE - Insufficient information to identify part of body effected. Includes damage to prosthetic devices.
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*UNS - UNSPECIFIED

**NEC - NOT ELSEWHERE CLASSIFIED

NOTICE
TO
EMPLOYEES



NOTICE
TO
EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - <http://www.state.ma.us/dia>

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

NAME OF INSURANCE COMPANY

ADDRESS OF INSURANCE COMPANY

POLICY NUMBER

EFFECTIVE DATES

NAME OF INSURANCE AGENT

ADDRESS

PHONE #

EMPLOYER

ADDRESS

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY)

DATE

MEDICAL TREATMENT

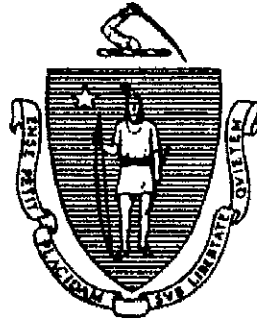
The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL

ADDRESS

TO BE POSTED BY EMPLOYER

**AVISO PARA
EMPLEADOS**



**AVISO PARA
EMPLEADOS**

The Commonwealth of Massachusetts
DEPARTMENT OF INDUSTRIAL ACCIDENTS
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
617-727-4900 - <http://www.mass.gov/dia>

De acuerdo con lo dispuesto por los artículos 21, 22 y 30 del capítulo 152 de las Leyes Generales de Massachussets, por el presente notificamos que hemos previsto el pago a nuestros empleados lesionados, conforme al capítulo antes mencionado, mediante un seguro con:

NOMBRE DE LA COMPAÑÍA DE SEGURO

DOMICILIO DE LA COMPAÑÍA DE SEGURO

NÚMERO DE PÓLIZA

FECHAS DE VIGENCIA

NOMBRE DEL AGENTE DE SEGUROS

DOMICILIO

TELÉFONO

EMPLEADOR

DOMICILIO

FUNCIONARIO DEL EMPLEADOR PARA ACCIDENTES DE TRABAJO (SI HUBIERA) FECHA

TRATAMIENTO MÉDICO

En caso de lesiones personales ocurridas a raíz del trabajo o durante el trabajo, la aseguradora cuyo nombre aparece arriba debe prestar servicios médicos y hospitalarios adecuados razonables de acuerdo con lo dispuesto por la Ley de Accidentes de Trabajo. El empleado lesionado debe recibir una copia del Primer Informe de Lesión. El empleado puede elegir su propio médico. El costo razonable de los servicios prestados por el médico que asista en el caso será abonado por la aseguradora, siempre que el tratamiento sea necesario y esté razonablemente relacionado con la lesión ocupacional. En caso de que se necesite atención hospitalaria, por la presente se notifica a los empleados que la aseguradora ha dispuesto que esa atención sea prestada en:

NOMBRE DEL HOSPITAL

DOMICILIO

ANUNCIO PUBLICADO POR EL EMPLEADOR