

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.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE
		JURISDICTION	JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER		
SIC CODE		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
				LOCATION # PHONE #

CARRIER/CLAIMS ADMINISTRATOR		
CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	TO	
	<input type="checkbox"/> CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE										
NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH	SOCIAL SECURITY NUMBER			DATE HIRED	STATE OF HIRE	
ADDRESS (INCL ZIP)				SEX		MARITAL STATUS			OCCUPATION/JOB TITLE	
				<input type="checkbox"/> MALE (M)	<input type="checkbox"/> FEMALE (F)	<input type="checkbox"/> UNKNOWN (U)	<input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U)			<input type="checkbox"/> MARRIED (M)
PHONE				# OF DEPENDENTS		SEPARATED (S)			EMPLOYMENT STATUS	
						UNKNOWN (K)			NCCI CLASS CODE	
RATE	PER:	DAY	MONTH	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?			YES	NO	
		WEEK	OTHER:		DID SALARY CONTINUE?			YES	NO	

OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN		
	PM			PM					
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?				TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
<input type="checkbox"/> YES <input type="checkbox"/> NO									

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTMITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				

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								CAUSE OF INJURY CODE	
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DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?			YES	NO
		WERE THEY USED?			YES	NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT	
					NO MEDICAL TREATMENT (0)	
					MINOR: BY EMPLOYER (1)	
					MINOR CLINIC/HOSP (2)	
					EMERGENCY CARE (3)	
					HOSPITALIZED > 24 HRS (4)	
					FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5)	
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER	

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/ SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE - This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS - Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

DAYS WORKED/ WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS - Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - The county where the injury occurred. If the injury did not occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - 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.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - 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 (e.g., 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 - 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.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK - Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
		JURISDICTION		JURISDICTION CLAIM NUMBER	
		INSURED REPORT NUMBER			
SIC CODE		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
				LOCATION # PHONE #	

CARRIER/CLAIMS ADMINISTRATOR					
CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)	
		<input type="checkbox"/> CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE			
CARRIER FEIN		POLICY/SELF-INSURED NUMBER		ADMINISTRATOR FEIN	
AGENT NAME & CODE NUMBER					

EMPLOYEE/WAGE									
NAME (LAST, FIRST, MIDDLE)			DATE OF BIRTH		SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE	
ADDRESS (INCL ZIP)			SEX <input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)		MARITAL STATUS <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)		OCCUPATION/JOB TITLE		
							EMPLOYMENT STATUS		
PHONE			# OF DEPENDENTS		NCCI CLASS CODE				
RATE PER:		DAY	MONTH	# DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?		YES	NO	
		WEEK	OTHER:		DID SALARY CONTINUE?		YES	NO	

OCCURRENCE/TREATMENT									
TIME EMPLOYEE BEGAN WORK		AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN	PM
		PM			PM				
CONTACT NAME/PHONE NUMBER				TYPE OF INJURY/ILLNESS			PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO				TYPE OF INJURY/ILLNESS CODE			PART OF BODY AFFECTED CODE		
COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED					ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED					WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				

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								CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK		IF FATAL, GIVE DATE OF DEATH		WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?				YES	NO
								YES	NO
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT	
WITNESSES (NAME & PHONE #)								NO MEDICAL TREATMENT (0)	
								MINOR: BY EMPLOYER (1)	
								HOSPITALIZED > 24 HRS (4)	
								FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED (5)	
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED		PREPARER'S NAME & TITLE				PHONE NUMBER	

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/ SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE - This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS - Indicate the employee's work status. The valid choices are: Full-time, Part-Time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-Time, Apprenticeship Part-Time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

DAYS WORKED/ WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS - Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - The county where the injury occurred. If the injury did not occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - 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.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - 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 (e.g., 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 - 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.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK - Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.

MWCC - WORKERS' COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER/ADMINISTRATOR CLAIM NUMBER		REPORT PURPOSE CODE	
		JURISDICTION	JURISDICTION CLAIM NUMBER		
		INSURED REPORT NUMBER			
SIC CODE		EMPLOYER FEIN		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)	
				LOCATION # PHONE #	

CARRIER/CLAIMS ADMINISTRATOR		
CARRIER (NAME, ADDRESS & PHONE NO)	POLICY PERIOD	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
	TO	
	<input type="checkbox"/> CHECK IF APPROPRIATE <input type="checkbox"/> SELF INSURANCE	
CARRIER FEIN	POLICY/SELF-INSURED NUMBER	ADMINISTRATOR FEIN
AGENT NAME & CODE NUMBER		

EMPLOYEE/WAGE						
NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER		DATE HIRED	STATE OF HIRE
ADDRESS (INCL ZIP)		SEX <input type="checkbox"/> MALE (M) <input type="checkbox"/> FEMALE (F) <input type="checkbox"/> UNKNOWN (U)	MARITAL STATUS <input type="checkbox"/> UNMARRIED/SINGLE/DIVORCED (U) <input type="checkbox"/> MARRIED (M) <input type="checkbox"/> SEPARATED (S) <input type="checkbox"/> UNKNOWN (K)		OCCUPATION/JOB TITLE	
					EMPLOYMENT STATUS	
PHONE		# OF DEPENDENTS			NCCI CLASS CODE	
RATE	PER:	DAY	MONTH	#DAYS WORKED WEEK	FULL PAY FOR DAY OF INJURY?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	WEEK	OTHER:			DID SALARY CONTINUE?	YES <input type="checkbox"/> NO <input type="checkbox"/>

OCCURRENCE/TREATMENT							
TIME EMPLOYEE BEGAN WORK	AM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	AM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
	PM			PM			
CONTACT NAME/PHONE NUMBER			TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO			TYPE OF INJURY/ILLNESS CODE		PART OF BODY AFFECTED CODE		
COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED				ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			
SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED				WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED			

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						CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK	IF FATAL, GIVE DATE OF DEATH	WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? WERE THEY USED?			YES <input type="checkbox"/>	NO <input type="checkbox"/>	
					YES <input type="checkbox"/>	NO <input type="checkbox"/>	
PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)		HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT			
				NO MEDICAL TREATMENT (0) <input type="checkbox"/>			
WITNESSES (NAME & PHONE #)				MINOR: BY EMPLOYER (1) <input type="checkbox"/>			
				MINOR CLINIC/HOSP (2) <input type="checkbox"/>			
				EMERGENCY CARE (3) <input type="checkbox"/>			
				HOSPITALIZED > 24 HRS (4) <input type="checkbox"/>			
				FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED (5) <input type="checkbox"/>			
DATE ADMINISTRATOR NOTIFIED	DATE PREPARED	PREPARER'S NAME & TITLE			PHONE NUMBER		

WORKERS' COMPENSATION - FIRST REPORT OF INJURY EMPLOYER'S INSTRUCTIONS

GENERAL INFORMATION

EMPLOYER (NAME & ADDRESS INCL ZIP) - The name and address of the entity employing or statutorily responsible for the employee.

SIC CODE - The code which represents the nature of the employer's business which is contained in the Standard Industrial Classification Manual published by the Federal Office of Management and Budget.

EMPLOYER FEIN - Employer's Federal Employer Identification Number.

CARRIER/ADMINISTRATOR CLAIM NUMBER - Carrier's claim or file number.

REPORT PURPOSE CODE - A code used with Electronic Data Interchange to define the specific purpose of the report. (Original, Cancel, Change, Correction)

JURISDICTION - State in which you are filing the claim (Mississippi).

JURISDICTION CLAIM NUMBER - Number assigned to claim by Mississippi Workers' Compensation Commission (to be completed by MWCC).

INSURED REPORT NUMBER - The number, if any, used by the employer to identify the claim.

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) - The name and address of the employer's facility where the employee was employed at the time of injury, if different from above.

LOCATION #/ PHONE # - The number, if any, assigned by the employer to identify its location where the injury occurred and the phone number.

CARRIER (NAME, ADDRESS & PHONE NO) - The licensed business entity issuing the contract of insurance and assuming financial responsibility for the claim on behalf of the employer.

POLICY PERIOD - The date that the contract/policy under which the claim occurred began and expired.

CHECK IF APPROPRIATE (SELF-INSURANCE) - An indicator that identifies the employer as one who retains the risks arising from their operations and bears the financial responsibility. A jurisdictionally approved or acknowledged employer, group fund, or association assuming financial risk and responsibility for their employee's worker's compensation claims.

CLAIMS ADMINISTRATOR - The business entity providing claim services on behalf of the carrier, or self-insured. The name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

CARRIER FEIN - Carrier's Federal Employer Identification Number.

POLICY/ SELF-INSURED NUMBER - The number assigned by the carrier to the insurance contract/policy for the employer; or any similar number assigned to a self-insured employer.

ADMINISTRATOR FEIN - Federal Employer Identification Number of Administrator.

AGENT NAME & CODE NUMBER - The name of the insurance agent and the agent's code number if known. This information should be found in the insurance policy.

EMPLOYEE/WAGE INFORMATION

NAME (LAST, FIRST MIDDLE) - Employee's legally recognized name.

ADDRESS - The mailing address used by the employee.

PHONE - A telephone number where the employee can be reached.

DATE OF BIRTH - The date the employee was born.

SOCIAL SECURITY NUMBER - A number assigned by the Social Security Administration used to identify the employee.

DATE HIRED - The date the injured worker began his/her employment with the employer under which the claim is being filed. If there have been multiple periods of employment, this would be the beginning date of the current employment period.

STATE OF HIRE - State where employee was hired.

SEX - The code which indicates the sex of the employee.

MARITAL STATUS - The code which indicates the marital status of the employee.

OCCUPATION/JOB TITLE - This is the primary occupation of the employee at the time of the accident or exposure.

EMPLOYMENT STATUS - Indicate the employee's work status. The valid choices are: Full-time, Part-time, Not Employed, On Strike, Disabled, Retired, Unknown, Apprenticeship Full-time, Apprenticeship Part-time, Volunteer, Seasonal, or Piece Worker.

NCCI CLASS CODE - A code which corresponds to the primary occupation which the employee was engaged at the time of accident/injury, or injurious exposure. Codes are found in the NCCI BASIC MANUAL FOR WORKERS' COMPENSATION AND EMPLOYERS LIABILITY INSURANCE.

RATE - The reported employee's wage rate at the time of injury.

DAYS WORKED/ WEEK - The number of days worked by the employee in a week.

FULL PAY FOR DAY OF INJURY - State whether employee was paid his full wages on the injury date.

DID SALARY CONTINUE - State whether employee's salary was continued by the employer in lieu of compensation benefits.

OCCURRENCE/TREATMENT INFORMATION

TIME EMPLOYEE BEGAN WORK - The time employee began work on date of injury.

DATE OF INJURY/ILLNESS - The date employee was injured.

TIME OF OCCURRENCE - The time employee was injured.

LAST WORK DATE - The date employee last worked following the injury.

DATE EMPLOYER NOTIFIED - The date on which the employer was notified of the injury.

DATE DISABILITY BEGAN - The date on which employee began losing time.

CONTACT NAME/PHONE NUMBER - Name and phone number of employer representative to be contacted for further information.

TYPE OF INJURY/ILLNESS - Briefly describe the nature of the injury or illness, (e.g., Lacerations to the forearm).

PART OF BODY AFFECTED - Indicate the part of body affected by the injury/illness, (e.g., Right Forearm, lower back).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES - Mark yes or no as applicable.

TYPE OF INJURY/ILLNESS CODE - The NCCI code which corresponds to the nature of the injury or illness. (NCCI Table 8: Nature of Injury Codes)

PART OF BODY AFFECTED CODE - The NCCI code which corresponds to the part of the body injured. (NCCI Table 7: Part of Body Codes)

COUNTY WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - The county where the injury occurred. If the injury did not occur in Mississippi, put "out of state".

ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED - 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.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED - 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 (e.g., 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 - 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.

CAUSE OF INJURY CODE - The NCCI code which identifies the cause of injury. (NCCI Table 9: Cause of Injury Codes)

DATE RETURN(ED) TO WORK - Enter the date following the most recent disability period on which the employee returned to work.

IF FATAL, GIVE DATE OF DEATH - Date of death of employee.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED/WERE THEY USED - Check applicable "yes" or "no" box.

PHYSICIAN/HEALTH CARE PROVIDER (NAME AND ADDRESS) - The name and address of the physician or health care professional providing initial treatment.

HOSPITAL (NAME AND ADDRESS) - The name and address of the hospital where employee was treated (if applicable).

INITIAL TREATMENT - Check applicable choices.

WITNESSES (NAME & PHONE #) - The name(s) and phone number(s) of any one who witnessed the accident.

DATE ADMINISTRATOR NOTIFIED - The date the carrier or claims administrator processing the claim received notice of the injury.

DATE PREPARED - The date this report was prepared.

PREPARER'S NAME & TITLE - The name and title of the person who prepared this report.

PHONE NUMBER - The phone number of the person who prepared this report.

MISSISSIPPI WORKERS' COMPENSATION
NOTICE OF COVERAGE

I. Please take notice that your Employer is in compliance with the requirements of the Mississippi Workers' Compensation Law, and [**select one**] [has been approved by the Mississippi Workers' Compensation Commission to act as a self-insurer], or [maintains workers' compensation insurance coverage with the following:]

(Name of insurance carrier or self-insurance group)

(address & telephone number)

II. Individual workers' compensation claims will be submitted to and processed by:

(Name of third party claims administrator or claims office)

(address & phone number)

III. This workers' compensation coverage is effective for the following period:
_____ to _____.

IV. All job related injuries or illnesses should be reported as soon as possible to your immediate supervisor, or to the person listed below:

(Name of employer contact person)

(Title & Department/Division)

V. Please be advised that any person who willfully makes any false or misleading statement or representation for the purpose of obtaining or wrongfully withholding any benefit or payment under the Mississippi Workers' Compensation Law may be charged with violation of Miss. Code Ann. §71-3-69 (Rev. 2000) and upon conviction be subjected to the penalties therein provided.

COMPENSACIÓN AL TRABAJADOR DE MISSISSIPPI

NOTIFICACIÓN DE COBERTURA

I. Por favor tome nota que su Empleador está en cumplimiento con los requisitos de la Ley de Compensación al Trabajador de Mississippi, y [**seleccione uno**] [ha sido aprobado por la Comisión de Compensación al Trabajador de Mississippi para actuar como asegurador de sí mismo], o [mantiene seguro de compensación al trabajador con el siguiente:]

(Nombre del asegurador o grupo de seguro propio)

(dirección y número de teléfono)

II. Los reclamos individuales de compensación al trabajador serán entregados y procesados por:

(Nombre del administrador de reclamos de terceros u oficina de reclamos)

(dirección y número de teléfono)

III. Esta cobertura de compensación al trabajador está en vigencia durante el siguiente periodo:

_____ hasta _____.

IV. Todas las lesiones o enfermedades laborales deben ser reportadas tan pronto como sea factible a su supervisor inmediato, o a la siguiente persona:

(Nombre de la persona de contacto del empleador)

(Título y departamento o división)

V. Por favor tenga presente que cualquier persona que intencionalmente hace cualquier declaración o representación falsa o engañosa con el propósito de obtener o retener erróneamente cualquier beneficio o pago bajo la Ley de Compensación al Trabajador de Mississippi puede ser acusado de infracción de Miss. Code Ann. §71-3-69 (Rev. 2000) y al ser condenado será sujeto a las penas provistas en ella.

Establishing a Managed Care Panel

Great American Insurance Group has contracted with Procura/Optum to provide customizable Physician and Clinic Networks for our insureds. These networks provide injured workers with industry leading care and medical treatment at significant cost savings to employers.

Most states have specific guidelines governing the right for an employer or employee to direct care in the event of an industrial injury. Some states require the establishment of a Medical Panel for the initial treatment of work-related injuries. Due to the significant cost savings associated with Medical Panels, Great American – Alternative Markets recommends that employers establish medical Panels for all work locations.

Mandatory Panel States: GA, PA, TN, VA

Medical Provider Network (Opt-in): California

Medical Panels will need to be established BEFORE you have your first claim. Please fill out the below questionnaire listing all work locations and send to:

AlternativeMarketsAccountServices@GAIG.COM

Once received, you will be contacted by a member of our account services team to discuss the needs of your business and how to best construct the medical panel that will deliver appropriate coverage to your employee population.

Questionnaire

Named Insured: _____

Location: _____

Address: _____

Contact name: _____

Contact phone number: _____

Employee count: _____

Current network: Yes No