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 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.

First Report
of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011, Helena, MT 59604-8011

		Worke	r				
Last Name	First Nan	ne	M.I.	Date of Birth	Social Security Number		
Mailing Address	<u> </u>		City	<u> </u>	State Postal Code		
Phone Number Education	Less Than High School	Gender	Marita	Status	Number	of Dependents	
	GED or High School Diploma Beyond High School	☐ Male ☐ Female ☐ Unknown		rried Separate dowed, Divorced, Single,		•	
		Wages		known			
Date Hired Gross earning	gs for four pay periods preceding th	ne injury	3				
Date/Amour			Date/Amo		Date/Amount /		
Employment Status Full-Time Part-Time H		nber of Days worked per w	eek Wage	Wage Period ☐ Hour ☐ We	eek 🔲 Month 🔲 Day	☐ Bi-Weekly	
☐ Volunteer ☐ Other In addition to gross earnings cited	above worker received	Estima	ted value if an	y Time	Employee began work		
Worked next scheduled shift C	Bonus Commissions Off work more than 4 work days	Other: Date Last Worked	Date of Retur		· - / /	ry Continued	
Yes No	Yes No Not Sure	Accident Des	crintion	Yes	□ No	Yes No	
Job Title	Description of Accident	Accident Des	Cription				
,							
Cause of Injury	Cause Code Part of Body	Part	Code Natu	re of Injury Natur	re Code Date of Injury	Time of Injury	
Date Disability Began	Date of Death	Name 1)	es of Witnesse	s 2)	3)		
Accident on Employer's Premises	Accident Address or Location			-,		<u> </u>	
Yes No	City	State	Pos	tal code			
Date Employer Notified	Accident Reported to			Safety Equip		quipment Used	
					, 10		
Attending Physician's Name	Address	Medica	State	Postal Code	e Phone Numb	er	
Hospital Name	Address		State	Postal Code	Phone Numb	er	
Type of initial medical treatment re	ceived No Treatment Eme	ergency Room/Urgent (Care Trea	itment on-site by Employ	rer or Medical Staff	ic/Dr. Office	
Hospital > 24 hours		Signatu			<u> </u>		
	nsation benefits due to the on-the-job i	njury, occupational diseas	e, or death of th				
authorizes the release to the workers' information (medical records, pursuan death. Lake understand that if Lebtoir	it to HIPAA, Public Law 104-191, 42	USC section 1301, et. sec	a., and section 3	39-71-604, MCA), that are	directly relevant to the claimed i		
Signature of Injured Worke	n or exert unauthorized control over wo er or Beneficiary	- -:-:::::::::::::::::::::::::::::::::		Date:	ecuted for theit.	1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (1980 (
Employer Name	n · n ·	Employ	er			PD 1150	
Employer Name	Doing Busine	SS as		Federal Emp	loyer Identification Number (1 ax 1.12)	
Mailing Address	City	State	Postal (Code	Phone Number		
Location of operation, if different f	rom mailing address		Nature of Bus	iness	Self-Insured Yes	No	
			SIC/NAICS (Code	_		
Employer is a Sole Proprietorship Partnership Sole Proprietorship Sole Proprietorship Sole Proprietorship Sole Proprietorship Partnership Corporation Limited Liability Company A member of the employer's (sole proprietor) family living in the employer's household.							
Do you have any reason to question If yes, please explain fully. Use sep					Was worker injured while ☐ Yes ☐ No	in your employ	
	,						
Prepared By	Official Title		Phone	Number	Date		
Payroll Classification Code under w	vhich you		1				
report Employee's wages	Authorized Emplo	yer's Signature			Date		
		Insure	r				
Claim Administrator Claim Number	Date Reported to Claim Adn	ninistrator:		re information is correct vextra sheets if box at right	with the following exceptions is checked)		
Claim Administrator Name	Cl.: \	desiminare A. I.I.	<u> </u>	<i>S</i>	Claim Administrator F	TZINY	
اللهمت	Claim A	dministrator Address			Claim Administrator F	EIN	
Insurer Name			In	surer FEIN			
Policy Number	-		Po	licy Effective Date	Policy Expiration Da	te	
EDD 804 (D.) ASSAULT				<u> </u>			
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First Report
of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011, Helena, MT 59604-8011

Worker

Last Name		•	First Nan	ne		M.I.	Date of	Birth	Se	ocial Securi	ty Number	
Mailing Address						City	State		State	Postal Code		
Phone Number	□GE	ss Than High Sc ED or High Sch yond High Scho	ool Diploma	Gender Male Fee	male	\ \ \ \ \ \ \ \ \ \ \ \ \ \	tal Status Aarried Vidowed, Di Jnknown	Separated		ried	Number o	of Dependents
					ges		/IIII/O W 17					
Date Hired	Gross earnings for	r <u>four</u> pay perio										
Date/Amount /												
Room & Board	l 🗌 Overtime 🔲	Bonus 🔲 Co	mmissions 🔲	Other:	stimated v					yee began v		
Worked next sched		ork more than es 🔲 No [Date Last Worked	l Date	e of Ret	urn to Work	Full wages	paid fo		jury Salar	y Continued Yes 🔲 No
Joh Tido	l n			Accident D)escri	ptio	n					
Job Title Description of Accident												
Cause of Injury	'	Cause Code	Part of Body		Part Code	: Na	ture of Injur	y Natur	e Code	Date o	of Injury	Time of Injury
Date Disability Be		Date of Death	•	l l	Names of l)	Witnes	ses	2)			3)	
Accident on Empl	Ci	ccident Addressity		State		Po	ostal code					
Date Employer No	otified	Accident Repo	orted to					Safety Equip		rovided	Safety Eqi Yes	uipment Used No
Attending Physicia	mla NI. ma ::		ddress	Med	lical	C		Postal Code		DI	N T 1	
Attending Physicia	n s Name	ń	adaress			State		Postal Code	:	Pr	one Numbe	r
Hospital Name		A	ddress			State		Postal Code	;	Ph	one Numbe	r
Type of initial med	lical treatment receive	ed 🔲 No Treat	ment Eme	ergency Room/Urg	gent Care	☐ Tr	reatment on-	site by Employ	er or M	ledical Staff	Clinic	c/Dr. Office
authorizes the releas information (medica death. <u>I also underst</u>	r workers' compensation to the workers' compensation to the conference of the compensation of the conference of the conf	ensation insurer HPAA, Public L kert unauthorized	(and its agents) aw 104-191, 42	and to the Montana USC section 1301, e	lisease, or o Uninsured et. seq., and	Employ d section	ers' Fund of: a 39-71-604, l am not entitle	Social Security MCA), that are of	records; directly	rehabilitation	on records; ar	nd all health care
er var vær vær vær vær vær vær vær vær vær væ	CONTINUE CON	9 (1664) 1666 (1666) 1666 (1666) 1666 (1666)	and traditional and trade to the trade to the trade to	Empl	loyer	T. 1 1888 1888 1888 1888 1888	1.70 1.100 (100 (100 (100 (100 (100 (100 (100	2. C. v. 1. Mar (Mar (Mar (Mar (Mar (Mar (Mar)) Mar) (Mar	na) i dan i dan i dan i	1000) 2000) 2000) 2000) 1000 (2000) .	nder i dent i senti s met s altet i videt s met	l e mais / shiii / shiai / same / same / same / some / some / some / some / some
Employer Name			Doing Busine					Federal Empl	loyer Id	lentification	n Number (1	ax I.D)
Mailing Address	-	City		State		Postal	l Code		Phon	ne Number		
<u> </u>	ion, if different from				SIC/	re of B	6 Code			Insured	☐ Yes	□ No
Employer is a Sole Proprietorship Partnership Injured worker is a Sole Proprietorship Partnership Company Corporation Limited Liability Company A member of the employer's (sole proprietor) family living in the employer's household.												
Do you have any reason to question this accident? Yes No If yes, please explain fully. Use separate sheet if you need additional space								Was worker injured while in your employ ☐ Yes ☐ No				
Prepared By		Officia	l Title			Phon	ne Number		Da	te		
Payroll Classification Code under which you report Employee's wages Authorized Employer's Signature												
Insurer												
Claim Administrator Claim Number Date Reported to Claim Administrator: The above information is correct with the following exceptions (Attach extra sheets if box at right is checked)												
Claim Administrator	Name		Claim A	dministrator Addre	:ss				[Claim Adm	inistrator FI	EIN
Insurer Name]	Insurer FEI	N				
Policy Number Policy Effective Date Policy Expiration Date							e					
ERD - 991 (Rev. 05/20)	(6 DF)		_							<u> </u>		

First Report
of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011, Helena, MT 59604-8011

Worker

Last Name First Name					M.I. Date of Birth Social Security Number					
Mailing Address					(City		State	Postal Code	
Phone Number	Education	Less Than High	School chool Diploma thool	Gender Male Fer	male	Marital Stat Married Widowe	i 🔲 Separa ed, Divorced, Singl		Number of D	ependents
Date Hired	Cross sar	nings for <u>four</u> pay pe			ges					
Date Filled	Date/Am		nods preceding t Date/A	. ,	Dat	e/Amount	,	Date/Amo		
☐ Volunteer ☐	us Part-Time [Other	Piece Worker	Seasonal Nu	umber of Days worked		Wage	Wage Period	•		Bi-Weekly
Room & Board	d 🔲 Overtin	ed above worker rec ne Bonus 0	Commissions 🗌	Es Other:	stimated valu	ue if any		ne Employee be		
Worked next sche	duled shift No	Off work more tha		Date Last Worked	d Date o	f Return to	Work Full wag ☐ Yes	es paid for date	of injury Salary Co	ontinued No
Job Title		Description of	Accident	Accident D	escrip)	tion				
Cause of Injury		Cause Code			D G 1	I.,		a. 1		
Cause of Injury		Cause Code	Part of Body	, 	Part Code	Nature of	1 Injury Na	ture Code I	Date of Injury Time	e of Injury
Date Disability Be	gan	Date of Deat	h		Names of W	itnesses	2)		3)	
Accident on Empl	oyer's Premis	es Accident Addr City	ess or Location	State		Postal co	ode			···
Date Employer N	otified	Accident Re	ported to				Safety Equ	ipment Provide No	Safety Equipm	
Attending Physicia	n's Name		Address	Med		tate	Postal Co	vde.	Phone Number	
			7 Indicor			······	r ostar Co	de	i none i vamber	
Hospital Name			Address		St	ate	Postal Co	ode	Phone Number	
		t received 🔲 No Tre	eatment	nergency Room/Urg	gent Care [Treatmen	nt on-site by Empl	oyer or Medical	Staff Clinic/Dr	r. Office
☐ Hospital > 24	hours			Signa	ature					
authorizes the releas information (medica death. <u>Lalso underst</u>	e to the worke I records, purs and that if I ob	rs' compensation insur	er (and its agents) : Law 104-191, 42	injury, occupational d) and to the Montana l 2 USC section 1301, e	lisease, or dea Uninsured En	nployers' Fu ection 39-71	nd of: Social Securit -604, MCA), that ar	ty records; rehabi e directly relevan	signing this claim for co ilitation records; and all at to the claimed injury, t."	l health care
	e of indice we	rect of Beneficially) 1000 (1000 (1000) 1000 (1000 (1000 (1000) 1000) 1000 (1000	Empl	oyer	(ma (mil) ma (ma () ma () ma () m	Date: ==::::::::::::::::::::::::::::::::::	and 1 mile 1	N 1984 1984 1984 1984 1984 1984 1984 1984 1984 1984 1	(ans.) 1960 1964 1964 1966 1966
Employer Name			Doing Busin	ecss as			Federal En	nployer Identific	cation Number (Tax I	.D)
Mailing Address		City		State	P	ostal Code		Phone Nur	mber	
		nt from mailing addr			SIC/N.	of Business AICS Code		Self-Insure	d Yes 🗌] No
Employer is a S	Sole Proprieto Limite	rship 🔲 Partner d Liability Company		worker is a 🔲 Sole I A member of the en			artnership 🔲 Co or) family living in		Limited Liability Co household.	mpany
		tion this accident? [separate sheet if you						Was worl	ker injured while in yo No	ur employ
Prepared By		Offic	ial Title			Phone Nun	nber	Date		
Payroll Classification report Employee's		,	1 1 15 1		<u> </u>		7			
			uthorized Empl	oyer's Signature Insu	ıror			Date		
Claim Administrator	Claim Numb	per Date Repor	rted to Claim Ad		Th		formation is correct sheets if box at rigi		wing exceptions	
Claim Administrator	Name		Claim I		ss			Claim	Administrator FEIN	
Insurer Name					#- <u></u>	Insurer	FEIN			
Policy Number			<u>. </u>	· · · · · · · · · · · · · · · · · · ·		Policy F	Effective Date	Polic	y Expiration Date	
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WORKERS' COMPENSATION

INSURANCE COVERAGE

EMPLOYEE NOTICE

Γ	(Insert business nan	ne and address her	re.)	٦	Date: Policy Number:
L					
standing f	e-named employer for the period of requirements.	's workers' com to	-		coverage is active and in good ployer meets all premium and
		<u>IF YOU</u>	ARE	INJUR	RED
					or insurer as soon as possible. You

liability company, member of a member-managed limited liability company, or corporate officer covered under the Montana Workers' Compensation Act must report an accident to the insurer within 30 days.

Report minor injuries to your employer whether or not you receive medical treatment. After you report the injury, your employer has 6 days to notify their insurer. You must submit a written First Report of Injury within 12 months from the date of the accident or within one (1) year from the knowledge of an occupational disease. You can submit this form to your employer, insurer, or the Department of Labor and Industry.

All employees sustaining a compensable work related injury or occupational disease, other than those who are exempted by statute (Section 39-71-401, MCA), are covered for medical and wage-loss benefits.

Prior to the Insurer's designation or approval of a Treating Physician you may choose your initial Health Care Provider.

You may continue to receive treatment from your initial health care provider unless the insurer designates a treating physician other than your initial health care provider. After providing you with a notice of a designated or approved treating physician, the insurer is no longer liable for treatment provided by other health care providers unless authorization is obtained to continue treatment.

For specific information about this policy, call or write your employer's insurance carrier:

(Insert insurer name, address and phone number here)

For general information about workers' compensation, call or write: Montana Department of Labor and Industry, Employment Relations Division, P.O. Box 8011, Helena, MT 59604-8011, Phone (406) 444-6532.

FAILURE TO POST THIS SIGN OR POSTING AN ALTERED SIGN IN THE WORKPLACE WILL RESULT IN A \$50 FINE AGAINST THE EMPLOYER!

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	

Great American Insurance Group, 301 E Fourth Street, Cincinnti, OH 45202. This is not intended as legal advice; if you have any questions or issues of a specific nature, you should consult appropriate legal or regulatory counsel to review the specific circumstances involved. 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. 1251-ALT-CA (06/20)

