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.

This form must be printed and sent to the NH Department of Labor and your insurance carrier

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

IMPORTANT; *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First Middle Initial Last
2. DOB:
3. Age:
4. Male __ Female __
5. SS No.:
6. Address: No. & St. City/Town
7. State:
8. Zip Code:
9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:
11. Occupation when injured:
12. Was this his/her regular occupation? If not, state regular occupation:
13. Wages per hr.:
14. No. hrs. worked per day:
15. No. days worked per week:
16. Average Weekly Earnings:
17. Was injured hired in N.H.?
18. Date employment began:
19. Date & Time of Injury:
20. Date disability began:
21. Was injured paid in full for this day?
22. Date supervisor/employer was first notified:
23. Name of Person notified:
24. Location/Jobsite where accident occured:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es):
27. Part(s) of body injured:
28. Estimated length of disability:
29. Has injured returned to work?
30. If so, what date?
31. At what occupation or job?
32. Returned at: Full Duty: ____ ____ Alternative/Light Duty: ____ ____
33. Equipment causing injury:
34. Were safeguards in place?
35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: __ Care provide by Employer only (on-site): __ Emergency care: __ Hospitalized: __
    Other: (Outpatient): ____ (Clinic): ____ (Office Visit): ____ (Other-explain): ____
37. Name of treating physician: Name of treating hospital:
38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:
40. Employers Federal ID:
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above:
43. City/State:
44. Zip:
45. Telephone Number:
46. Insurance Co. (**not agent**) or Self Insured Group:
47. Managed Care Program? Y or N. If yes, name Provider:
48. No. of Employees: Full-time: Part-time:
49. Is there a Written Safety Program **in force**?
50. Is there an **active** Safety Committee?
51. Business SIC Code
52. Type or Nature of Business in N.H.:
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title:
56. Employee Signature (**whenever** possible):
57. Date of this report:

THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

Employer's Supplemental Report of Injury

> This report, indicating disability of an employee of four or more days, shall be filed as soon as possible after date of knowledge of an occupational injury or disease, but no later than ten days thereafter. Consistent failure to make this report available to the labor commissioner and the nearest claims office of your insurance carrier carries an automatic civil penalty of up to $100.00. (RSA 281-A:53) This report shall also be submitted upon employee's return to work.

1. Name of Employer ______________________ Employer's Identification No. ______________
   (9 digit number assigned by proper Federal Agency)
2. Address ____
   (No. and St.) (City and State) (Zip Code)
3. Insured by ____
4. Name of Employee ____
   (First Name) (Middle Initial) (Last Name) (S.S. Number)
5. Address ____
   (No. and St.) (City and State) (Zip Code)
6. Date of injury ______________________________ 19______
7. Date Disability began ______________________ 19______ A.M. ______ P.M. ______
8. ____
   (Specific dates of disability)
   ____
   (Specific dates of disability)
9. Has injured returned to work? ______ if so, date and hour ______________ A.M. ______ P.M. ______
10. Is injured person earning same wages as before injury? ______ If not, explain ______________
    ____

Date of Report ____

Signed by ______________________

Official Title ______________________

Tel. No. ______________________

WHITE – LABOR DEPT. CANARY – INSURANCE CLAIMS OFFICE PINK – EMPLOYER'S COPY

STATE OF NEW HAMPSHIRE

WORKERS' COMPENSATION LAW

NOTICE OF COMPLIANCE

TO EMPLOYEES

1 You are required by law (RSA 281-A:19) to report promptly to your employer an occupational injury or disease, even if you deem it to be minor. Form No. 8a WCA, Notice of Accidental Injury or Occupational Disease, may be used for that purpose (RSA 281-A:20,21). After you have completed and made it available to him or her, your employer must acknowledge receipt by signing and giving you a copy.

2 You are entitled to the services of a physician. This physician shall be within a managed care network, if applicable under RSA 281-A:23a.

3 You may not sue your employer as a result of a work-connected injury or disease by reason of your eligibility for benefits under the Workers' Compensation Law.

TO EMPLOYERS

1 You are required to display this poster so that it will be of the greatest possible benefit to your employees (RSA 281-A:4).

2 You are required to file an Employer's First Report of Injury or Occupational Disease, form No. 8 WC, with the Labor Commissioner, copy to the nearest claims office of your insurance carrier, on all occupational injuries or diseases resulting in one visit to a physician, other than a house physician, as soon as possible but no later than five days after the date of knowledge thereof (RSA 281-A:53, I).

3 You are required to report to the Labor Commissioner, copy as in 2 above, any occupational disability, whether total or partial, of four or more days (RSA 281-A:22), on an Employer's Supplemental Report of Injury, form No. 13 WCA, as soon as possible, but no later than ten days after the date of knowledge thereof (RSA 281-A:53,I and II).

4 You are required to furnish, or cause to be furnished, reasonable medical and hospital services, other remedial care or vocational rehabilitation, and various types of disability compensation, to an injured or disabled employee in accordance with RSA 281-A:23, 25, 26, 28, 29, 31, 32.

5 All employers with 5 or more full time employees shall develop temporary alternative work opportunities for injured employees in accordance with RSA 281-A:23-b. Employers may be obligated to reinstate employees sustaining a compensable injury in accordance with RSA 281-A:25-a.

6 You are required to obtain from the carrier identified below a supply of all required workers' compensation forms. NOTICE – Violation of the various provisions of the Workers' Compensation Law carries civil penalties, court fines, or both.

David M. Wihby Deputy Labor Commissioner	George N. Copadis Labor Commissioner

The undersigned employer hereby gives notice of compliance with all provisions of the Workers' Compensation Law and Administrative Regulations of the Labor Commissioner of the State of New Hampshire pursuant to Revised Statutes Annotated, Chapter 281-A, as amended.

Name of Insurance Company Or self-insurer:	Name of Employer: By ______________________ ______________________ Employer Identification No. (If number unknown, Employer to request from IRS)

This notice must be posted conspicuously in and about the Employer's place or places of business.

Prescribed by Labor Commissioner
State of New Hampshire
WCP-1 (1-99)

ESTADO DE NEW HAMPSHIRE
LEY DE COMPENSACIÓN PARA TRABAJADORES
(*WORKERS' COMPENSATION LAW*)
NOTIFICACIÓN REFERENTE AL CUMPLIMIENTO CON LA LEY IMPERANTE

A TODO EMPLEADO

1 A tenor de la ley (RSA 281-A:19), a usted se le requiere reportar oportunamente a su empleador (empresa contratante) cualquier lesión o enfermedad de carácter laboral, aunque usted considere que la lesión o enfermedad sufrida no es significativa. El formulario Núm. 8a WCA, *Notice of Accidental Injury or Occupational Disease*, es utilizado para dicho propósito ((RSA 281-A:20,21). Después de llenar debidamente el formulario, entrégueselo al representante apropiado de la empresa contratante, el cual deberá acusar de recibo del mismo firmándolo y entregándole una copia.

2 Usted tendrá derecho a ser atendido por un médico. Si fuere aplicable a tenor del reglamento RSA 281-A:23ª, dicho médico será un proveedor integrado a una red de cuidado coordinado (*managed care network*).

3 Si sufriera una lesión o enfermedad de carácter laboral y calificara para ser indemnizado a tenor de la Ley de Compensación para Trabajadores, usted no podrá demandar a la empresa contratante por concepto de la lesión o enfermedad sufrida.

A LA EMPRESA CONTRATANTE

1 A tenor de la ley imperante, a usted se le requiere fijar esta notificación en el lugar más propicio para sus empleados (RSA 281-A:4).

2 A usted se le requiere remitir el formulario Núm. 8 WC, *Employer's First Report of Injury or Occupational Disease*, al Comisionado de Trabajo y una copia del mismo a la oficina de reclamaciones de su compañía de seguros más cercana, por concepto de toda lesión o enfermedad de carácter laboral que resultase en una consulta con un médico, aparte de uno de los médicos de planta (*house physician*). Dicho formulario tendrá que ser remitido a las precitadas entidades, lo antes posible, pero a mas tardar al quinto día después de la fecha en que usted se haya enterado de la lesión o enfermedad (RSA 281-A:53, I).

3 A usted se le requiere remitir al Comisionado de Trabajo: una copia del formulario indicado en el precitado inciso 2, así como los datos pertinentes a una incapacidad, ya sea total o parcial, de carácter laboral, que perdurara por cuatro días o más (RSA 281-A:22) en el formulario Núm 13 WCA, *Employer's Supplemental Report of Injury*, lo antes posible, pero a mas tardar al décimo día después de la fecha en que usted se haya enterado de la lesión o enfermedad (RSA 281-A:53, I and II).

4. A tenor de los reglamentos RSA 281-A:23, 25, 26, 28, 29, 31, 32, a usted se le requerirá suministrar, o hacer los arreglos necesarios para que se le suministre, a cualquier empleado lesionado o incapacitado los servicios médicos y hospitalarios que fueren apropiados, así como cualquier otra atención curativa, rehabilitación vocacional y los diversos tipos de indemnización por incapacidad que fueren aplicables.

5 A tenor del reglamento RSA 281-A:23-b., a toda empresa contratante que cuente con 5 ó más empleados de tiempo completo se le requerirá proporcionar a los empleados lesionados la oportunidad de trabajar temporalmente en un puesto alternativo. A tenor del reglamento RSA 281-A:25-a, a las empresas contratantes se les podría exigir recontratar a los empleados que hayan sufrido lesiones compensables.

6 A usted se le requiere obtener, de la compañía de seguros indicada a continuación, todos y cada uno de los formularios requeridos relacionados con la compensación para trabajadores.

ADVERTENCIA — La violación a las precitadas disposiciones de la Ley de Compensación para Trabajadores ocasionará la aplicación de penalidades civiles, multas judiciales o ambas.

James D. Casey
Comisionado de Trabajo

Por medio de la presente, la infrascrita empresa contratante hace constar que se regirá por todas y cada una de las disposiciones de la Ley de Compensación para Trabajadores y los Reglamentos Administrativos del Comisionado de Trabajo del estado de New Hampshire (*Labor Commissioner of the State of New Hampshire*), a tenor del enmendado Capítulo 281-A de Inscripción Actualizada de los Estatutos (*Revised Statutes Annotated, Chapter 281-A*).

Nombre de la compañía de seguros o entidad autoasegurada:	Nombre de la Empresa Contratante:
	Por: ______________________
	Número de Identificación Patronal (*Employer Identification Number*) (Si el número no está disponible, la Empresa Contratante tendrá que solicitarlo al IRS.)

Esta notificación tiene que ser FIJADA en un sitio visible en el lugar de trabajo o establecimientos comerciales de la Empresa Contratante.
Ordenado por el Comisionado de Trabajo
WCP-1 (1-99) Estado de New Hampshire

NOTICE
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