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

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.

FORM 2

Send original to
Workers' Compensation Court and 1 copy to
Insurance Carrier
Please type or print. Enter all dates in MM/DD/YY format.

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

EMPLOYER'S FIRST NOTICE OF INJURY

THIS SPACE FOR COURT USE ONLY

Full Name of Employee - LAST, FIRST, MIDDLE		Employee Email Address	
Complete Address	City	State	Zip
Telephone Number	Social Security Number		
Date of Birth	Sex	Length of Employment Years Months	
Average Weekly Wage	Occupation (job description)	Was employment agreement made in Oklahoma? YES ☐ NO ☐	

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or In-State Toll Free (800) 522-8210.

Date of accident or last exposure	Time of accident or exposure o'clock AM ☐ PM ☐	Date Employer Notified	Time workday began o'clock AM ☐ PM ☐
Last date employee worked	Has employee returned to work? YES ☐ NO ☐ If yes, on what date	Did the employee die? YES ☐ NO ☐ If yes, on what date	
OSHA Log Case #	Place of Accident or Occurrence City:	County:	State:

Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational Disease ☐

Nature of Injury or Illness	Does employee participate in a certified workplace medical plan: YES ☐ NO ☐ If yes, name of CWMP:

Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.

Identify part(s) of body involved in injury or illness

Full Name and address of Treating Physician (please be complete)

Employer's Insurance Carrier or Own Risk Group		Policy/Self-Insured Number	
Name	Phone	Policy Period—from _____ to _____	
Address	City	State	Zip
Employer's Name and Complete Address			
Name	Federal ID#	Phone #	
Address	City	State	Zip
Type of business (Example: manufacturing, food service, construction)		NAICS Number	

Type of Ownership: Private ☐ State Government ☐ County Government ☐ Local Government ☐

Upon filing this Notice of Injury, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter relating to the notice.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall within seven (7) days report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

The undersigned hereby declares under penalty of perjury that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this Form 2 was sent to the Workers' Compensation Court and a copy thereof to the employer's insurer on the date noted below:

Signed _____
Signature of Preparer

By _____
Name and Title of Preparer (Please Print)

Telephone Number _____
Area Code and Number

Date _____

A Form 2 must be filed with the Workers' Compensation Court and sent to the Employer's workers' compensation insurance carrier within 10 days of notice that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise. Form 2s filed with the Workers' Compensation Court are confidential and not subject to public disclosure except as authorized by law.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY OR THAT THE EMPLOYEE HAS PROVIDED PROPER NOTICE OF INJURY.

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WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

EMPLOYER'S FIRST NOTICE OF INJURY

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Full Name of Employee - LAST, FIRST, MIDDLE			Employee Email Address
Complete Address	City	State	Zip
Telephone Number		Social Security Number	
Date of Birth	Sex	Length of Employment Years	Months
Average Weekly Wage	Occupation (job description)		Was employment agreement made in Oklahoma? YES ☐ NO ☐

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Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational Disease ☐

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Name	Phone		Policy Period—from _____ to _____
Address	City	State	Zip
Employer's Name and Complete Address			
Name	Federal ID#		Phone #
Address	City	State	Zip
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1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

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Complete Address	City	State	Zip
Telephone Number		Social Security Number	
Date of Birth	Sex	Length of Employment Years	Months
Average Weekly Wage	Occupation (job description)		Was employment agreement made in Oklahoma? YES ☐ NO ☐

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Telephone Number _____
Area Code and Number

Date _____

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Form 1A

Oklahoma Workers' Compensation Notice and Instruction to Employers and Employees

All employees of this employer who are entitled to benefits of the Workers' Compensation Code are hereby notified that this employer has complied with all rules of the Workers' Compensation Court and that this employer has secured payment of compensation for all employees and their dependents in accordance with the Code. All employees are further notified this employer will furnish first aid, medical, diagnostic, surgical and any other like services required by law as well as payments of compensation to any injured employee as provided in the Workers' Compensation Code.

Any employee who has suffered a compensable injury covered by the Workers' Compensation Code shall be entitled to vocational rehabilitation services, including retraining and job placement, if, as a result of the injury, the employee is unable to perform the same occupational duties the employee was performing prior to the injury.

The Oklahoma Workers' Compensation Court has a counselor (ombudsman) program to provide information to injured workers, employers, and other interested parties.

Mediation is available to address certain workers' compensation disputes.

For information, call 405-522-8760 or In-State Toll Free 800-522-8210.

Signature of Employer

Insurer & Insurer Phone Number

Employee's Responsibilities In Case of Work Related Injury

If accidentally injured or affected by cumulative trauma or an occupational disease arising out of and in the course of employment, however slight, the employee should notify the employer immediately. If this employer is a partnership, notice shall be given to any partner. If this employer is a corporation, notice shall be given to any agent or officer of the corporation upon whom legal process may be served. Notice shall also be given to the person in charge of business at the location of operations where the injury occurred. Unless notice is given to the employer or medical treatment is rendered within thirty (30) days of injury, any claim for compensation may be forever barred.

If accidentally injured or affected by cumulative trauma or an occupational disease, the employee may file a claim for compensation with the Workers' Compensation Court. Forms to file a compensation claim should be furnished by this employer and also are available from the Workers' Compensation Court. The forms are posted on the Court's web site, www.owcc.state.ok.us/court_forms.htm.

A claim for compensation must be filed with the Court within the time specified by law, or be forever barred. Based on law effective August 26, 2011, a claim for compensation for any accidental injury or death must be filed with the Court within two (2) years from the date of the accidental injury or death; a claim for compensation for occupational disease must be filed within two (2) years of either the last hazardous exposure or from the date the disease first became manifest, which ever last occurred; and a claim for compensation for cumulative trauma must be filed within two (2) years of when the employee was last employed by the employer. Provided, claims may be filed within two (2) years from the date of the last medical treatment authorized by the employer or payment of any compensation or remuneration paid in lieu of compensation.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall within seven (7) days report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Employer's Responsibilities

The employer must provide employees with immediate first aid, medical, diagnostic, surgical and any other like services that are reasonable and necessary. This applies to care for all injuries and illnesses arising out of and in the course of employment, regardless of their character. If an employee is injured and this results in the loss of time beyond his/her shift, or requires medical attention away from the work site (fatal or otherwise), the employer MUST file a Form 2 with the Workers' Compensation Court within ten (10) days of the notice of injury. The employer must provide a copy of the Form 2 to the employer's workers' compensation insurance carrier, if any.

No agreement by any employee to pay any portion of premiums paid by the employer to maintain or carry compensation insurance as required by law shall be valid. Any employer who deducts money from the wages or salary of any employee for that purpose who is entitled to workers' compensation shall be guilty of a misdemeanor.

If the employer has actual notice of an undisputed injury and the employer's insurance carrier fails to commence weekly temporary total disability benefit payments due within the time provided by law, the insurer shall pay to the employee a penalty of fifteen percent (15%) of the unpaid or delayed weekly benefits.

No agreement by any employee to waive workers' compensation rights and benefits shall be valid.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Workers' Compensation Court
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Tele. 405- 522-8600 (OKC) · 918 -581-2714 (TU) · In-State Toll Free 800-522-8210
Web Site · www.owcc.state.ok.us

This notice must be posted and maintained by the employer in one or more conspicuous places.

Notificación de Compensación para Trabajadores de Oklahoma e Instrucciones para Empleadores y Empleados

Formulario 1A

Por el presente, se notifica a todos los empleados de este empleador con derecho a los beneficios del Código de Compensación para Trabajadores, que el empleador mencionado ha cumplido con todas las normas del Tribunal de Compensación de los Trabajadores y que ha garantizado el pago de la compensación de todos los empleados y de las personas a su cargo, de acuerdo con el Código. Además, se notifica a todos los empleados que este empleador prestará servicios de primeros auxilios, de diagnóstico, médicos, quirúrgicos y cualquier otro servicio similar exigido por ley así como también los pagos de compensación a cualquier empleado que sufra lesiones según lo establecido en el Código de Compensación para Trabajadores.

Cualquier empleado que haya sufrido una lesión compensable cubierta por el Código de Compensación para Trabajadores tendrá derecho a los servicios de rehabilitación vocacional, incluidas la reeducación y la colocación laboral si, como resultado de la lesión, el empleado no puede llevar a cabo las mismas obligaciones laborales que desempeñaba antes de producirse la lesión.

El Tribunal de Compensación de los Trabajadores de Oklahoma tiene un programa de asesores (defensor del pueblo) para brindar información a los trabajadores lesionados, empleadores y a otras partes interesadas.

La mediación está disponible para tratar ciertas controversias que surjan de la compensación para trabajadores.

Para obtener información, llame al 405-522-8760 o llame de forma gratuita dentro del estado al 800-522-8210.

Firma del Empleador

Compañía Aseguradora y Número Telefónico de la Compañía

Responsabilidades del Empleado en Caso de Lesión Laboral

En caso de que el empleado sufra lesiones accidentalmente o que resulte afectado por trauma acumulativo o una enfermedad ocupacional ocasionada por el empleo o durante el empleo, por muy leve que sea, el empleado debe notificar de inmediato al empleador. Si el empleador es una sociedad de personas, se debe notificar a cualquier socio. Si el empleador es una sociedad anónima, se debe notificar a algún representante o funcionario de la sociedad sobre quién se emprenderán las acciones legales. Además, se debe notificar a la persona responsable de la empresa en el lugar de las operaciones comerciales en donde se produjo la lesión. Salvo que se notifique al empleador o se realice el tratamiento médico dentro de los treinta (30) días de producida la lesión, cualquier reclamo por compensación prescribirá para siempre.

En caso de que el empleado sufra lesiones accidentalmente o que resulte afectado por trauma acumulativo o una enfermedad ocupacional, puede presentar una demanda por compensación ante el Tribunal de Compensación de los Trabajadores. Los formularios para presentar una demanda por compensación deben ser proporcionados por este empleador y además estarán disponibles en el Tribunal de Compensación de los Trabajadores. Los formularios se publican en el sitio Web del Tribunal, www.owcc.state.ok.us/court_forms.htm.

El reclamo por compensación debe presentarse ante el Tribunal dentro del plazo especificado por ley o prescribirá para siempre. Según la ley vigente del 26 de agosto de 2011, un reclamo por compensación en caso de cualquier lesión accidental o muerte se debe presentar ante el Tribunal dentro de los dos (2) años a partir de la fecha en que se produjo la lesión o muerte; un reclamo por compensación en caso de enfermedad laboral se debe presentar dentro de los dos (2) años desde la última exposición peligrosa o a partir de la fecha en que se manifestó por primera vez la enfermedad, cualquiera sea la que sucedió por última vez, y un reclamo por compensación en caso de trauma acumulativo se debe presentar dentro de los dos (2) años a partir de la fecha en que el empleado fue contratado por última vez por el empleador, siempre y cuando, los reclamos puedan presentarse dentro de los dos (2) años a partir de la fecha del último tratamiento médico autorizado por el empleador o del pago de cualquier retribución o remuneración pagada en lugar de indemnización.

Cualquier persona que recibe de un empleador o de la compañía aseguradora del empleador beneficios temporarios por incapacidad informará por escrito dentro de los siete (7) días al empleador o a dicha compañía sobre cualquier cambio en un hecho relevante, en la cantidad de ingresos que está recibiendo el empleado o en el status laboral del empleado, cambio que se haya producido durante el período de recibo de dichos beneficios.

Responsabilidades del Empleador

El empleador debe prestar a los empleados servicios inmediatos de primeros auxilios, de diagnóstico, médicos, quirúrgicos y cualquier otro servicio similar que sea razonable y necesario. Esto se aplica al cuidado de todas las lesiones y enfermedades ocasionadas por el empleo y durante el empleo, independientemente de su naturaleza. Si un empleado sufre una lesión (mortal o distinta) y esto tiene como resultado la pérdida de tiempo fuera del horario de su turno o requiere atención médica lejos del sitio de trabajo, el empleador DEBE presentar un Formulario 2 ante el Tribunal de Compensación de los Trabajadores dentro de los diez (10) días de la notificación de la lesión. El empleador debe proporcionar una copia del Formulario 2 a la compañía aseguradora de compensación de los trabajadores del empleador, si hubiere.

No tendrá validez ningún convenio, realizado por cualquier empleado, para pagar una parte de las primas abonadas por el empleador con el fin de mantener o llevar el seguro de accidentes como lo exige la ley. Cualquier empleador que, para ese fin, descuente dinero de los sueldos o salarios de los empleados con derecho a compensación de los trabajadores será culpable de delito menor.

Si el empleador ha recibido notificación fehaciente de una lesión innegable y su compañía aseguradora no comienza con los pagos debidos en concepto de beneficio semanal por incapacidad temporal total dentro del plazo establecido por ley, la compañía aseguradora pagará al empleado una multa del quince por ciento (15%) de los beneficios semanales impagos o retrasados.

No tendrá validez ningún convenio, realizado por el empleado, para renunciar a los derechos y beneficios de compensación de los trabajadores.

Cualquier persona que cometa fraude de compensación de trabajadores será culpable de delito grave con condena.

Tribunal de Compensación de los Trabajadores
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105-4918
Teléfono: 405- 522-8600 (OKC) · 918 -581-2714 (TU) · Llamada gratuita dentro del estado, 800-522-8210
Sitio web · www.owcc.state.ok.us

Esta notificación debe ser publicada y conservada por el empleador en uno o más lugares visibles.