### 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.

## **Report of Job Injury or Illness**

Workers' compensation claim

### Worker

				V	V OFK	er					
To make a claim for a work-refile a workers' compensation											d to
Date of			comp	any,			a.m.		•	DEPT I	ISF-
injury or illness:		e you work:				ou began work of injury:	☐ p.m.	Regularly so days off:	heduled	Emp	3012.
		ne you	Па	.m.		ere if you have mor	• • • • • • • • • • • • • • • • • • • •			ļ	
or illness:	.m. left	work:	□р	.m.	job: 🔲			MTWT	F S S	Ins	
What is your illness or injury	? What par	t of the body? W	hich si	de? (I	Example:	Sprained right foo	t) 🗆	Left Righ	t	Occ	
								<u></u>		Nat	
What caused it? What were you				ery, c	r tool use	ed. (Example: Fell	10 feet when	n climbing an		Part	
extension ladder carrying a 40	-pouna bo	ox of rooting mate	eriais)							Ev	
								Src			
										2src	
Information ABOVE this line; date	e of death, ij	death occurred; an	d Orego	n OSF	IA case log	number must be rele	ased to an aut	horized worker	representat	ive upon re	quest.
Your legal name:			I	angu	age prefe	rence:	Birth	ndate:	Ge	nder: M [	_] F [_
Your mailing address:								Home pho	one:		
Social Security no. (see Form	3283):		(	Occup	oation:			Work pho	Work phone:		
Names of witnesses:											
Name and phone number of h	ealth insur	ance company:				Name and addres injury or illness y			who treate	ed you for	the :
Were you hospitalized overni	ght?	☐ Yes	□ N	0							
Were you treated in the emerg											
By my signature, I am making authorize health care providers employer, claim administrator, a treatment for the same condition HIV/AIDS records, certain drug I understand I have a rigital Worker	and other cand the Order or of injugated and alcoholic and alcoholic	ustodians of claim egon Department of pries to the same a of treatment record	record of Cons rea of t ds, and ider of Con	ls to re umer he boo other my el nplete	elease rele and Busir dy. A HIP records p hoice sub ed by	evant medical record less Services. Notice AA authorization is rotected by state and	ds to the work e: Relevant is not required d federal law	kers' compensa medical record d (45 CFR 164 requires separ	ation insures include a .512(I)). Frate author	rer, self-in records of Release of rization.	prior
signature:			(ple	ase pi	rint):					Date:	
					nploy						
Complete the rest of this form	and give a	copy of the forn	n to the	work	er. Even	if the worker does	not want to	file a claim, k	teep a cor	y of this	form.
business name:	Employer legal business name: Phone: FEIN:										
If worker leasing company,  Client											
list client business name: FEIN:											
Address of principal place of business (not P.O. Box):  Insurance policy no.:											
Street address from which  Nature of business in							which w	orker			
worker is/was supervised:  ZIP: is/was supervised:											
Address where event occurred:											
Was injury caused by failure of	f a machii	ne or product, or l	by a pe	rson	other than	the injured worke	er? 🔲 Yes	□No			
Were other workers injured?	☐ Yes ☐	] No					OSHA 300	log case no:			
Date employer knew of claim:					er	If fatal, date of death:					
By my signature, I acknowledge understand I may not restrict											
Employer			Name								
signature:			(pleas	e prir	it):				Date:		

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

## **Report of Job Injury or Illness**

Workers' compensation claim

### Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give it to your employer. If you do not intend to										
file a workers' compensation clai	m with the insurance company,	do not sign the signature li	ine. Your en	nployer will give you a	сору.					
Date of	Date you	Time you began work	☐ a.m.	Regularly scheduled	DEPT USE:					
injury or illness:	left work:	on day of injury:	□ p.m.	days off:	Emp					

	a.m.	Time you	∐ a.r	- 1		ere if you have more	than one	M T W T F		Ins
	p.m.	left work:	p.ı ∐ biob gid		job:	Sansinad right fact	, <u> </u>		33	Occ
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot)										
										Nat
What caused it? What were				ry, o	r tool use	d. (Example: Fell 1	10 feet when	climbing an		Part
extension ladder carrying a 4	10-pour	nd box of rooting mate	eriais)							Ev
									Src	
		4		_						2src
Information ABOVE this line; da	ite of dei	ath, if death occurred; an	d Oregon	OSF	IA case log	number must be rele	ised to an aut	horized worker re	presentat	ive upon request.
Your legal name:			La	angu	age prefe	rence:	Birth	date:	Ge	nder: M 🔲 F 🔲
Your mailing address:								Home phor	ne:	
Social Security no. (see Form	n 3283)	):	О	ecup	oation:			Work phor	ie:	
Names of witnesses:										
Name and phone number of	health i	insurance company:				Name and addres			ho treate	ed you for the
						injury or illness y	ou are now	reporting:		
Were you hospitalized overn	night?	☐ Yes	☐ No							
Were you treated in the emer										
By my signature, I am makin										
authorize health care providers employer, claim administrator,										
treatment for the same condition	ons or o	of injuries to the same a	rea of th	e bo	dy. A HIP	AA authorization is	not required	l (45 CFR 164.5	512(I)). F	Release of
HIV/AIDS records, certain dru	_				_	-				
I understand I have a rig	gnt to s	see a neam care provi	Com			ect to certain restr	ictions und	er UKS 656.260	J and OI	KS 656.325.
signature:			(plea						1	Date:
Employer										
Complete the rest of this form	n and g	give a copy of the forn					not want to	file a claim, ke	ep a cor	y of this form.
Employer legal business name: Phone: FEIN:										
If worker leasing company,					I non			Client		
list client business name:								FEIN:		
Address of principal place								Insurance		
of business (not P.O. Box):								policy no.:		
Street address from which						<b>7.1</b> 0				which worker
worker is/was supervised:						ZIP:		is/was superv	/ised:	
Address where event occurred:										
Was injury caused by failure	of a m	achine or product, or	oy a per	son (	other than	the injured worke	r? 🗌 Yes	☐ No		
Were other workers injured? ☐ Yes ☐ No OSHA 300 log case no:										
Date employer knew of claim:		ate worker turned to work:			rker's ekly wage	9	Date work hired:	er	If fatal, of death	
			z my wo					five days of kno		
By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.										
Employer			Name a							
signature:			(please			6 . 1		2011	Date:	
OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or										

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

### **Report of Job Injury or Illness**

policy no.:

OSHA 300 log case no:

Date worker

hired:

is/was supervised:

Nature of business in which worker

If fatal, date

Workers' compensation claim

		$\mathbf{W}$	ork	er					
To make a claim for a work-related file a workers' compensation clai		the worker	portio	- 1 of this form and					
Date of	Date you	l 7	rime vo	ou began work	☐ a.m.	Regularly schedu	led DEPT USE:		
injury or illness:	left work:		-	of injury:	□ p.m.	days off:	Emp		
Time of injury a.m.	Tîme you [	a.m. (	Check h	re if you have more than one			Ins Ins		
or illness:									
What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot)									
What caused it? What were you do			tool us	ed. (Example: Fel	l 10 feet wher	climbing an	Part		
extension ladder carrying a 40-pour	nd box of roofing materia	als)					Ev		
							Src		
							2src		
Information ABOVE this line; date of de	ath, if death occurred; and O	regon OSHA	case log	number must be re	leased to an auti	horized worker represe	entative upon request.		
Your legal name:		Languag	ge prefe	erence:	Birth	date:	Gender: M 🔲 F 🗍		
Your mailing address:						Home phone:			
Social Security no. (see Form 3283): Occupation: Work phone:									
Names of witnesses:									
Name and phone number of health insurance company:  Name and address of health care provider who treate injury or illness you are now reporting:									
Were you hospitalized overnight?	☐ Yes ☐	] No							
Were you treated in the emergency									
By my signature, I am making a cla authorize health care providers and of employer, claim administrator, and the treatment for the same conditions or of HIV/AIDS records, certain drug and a lunderstand I have a right to	ther custodians of claim re e Oregon Department of C of injuries to the same area alcohol treatment records,	cords to rele Consumer and of the body and other re	ase relo d Busin . A HIF cords p	evant medical reconess Services. Note AA authorization rotected by state a	rds to the work ice: Relevant r is not required and federal law	ters' compensation in medical records included (45 CFR 164.512(I requires separate au	insurer, self-insured ude records of prior ()). Release of uthorization.		
Worker		Completed							
signature: (please print):							Date:		
Complete the rest of this form and g	give a copy of the form to	Em			es not want to	file a claim, keep a	copy of this form.		
Employer legal							· — —		
business name:			Phor	ie:		FEIN:			
If worker leasing company,						Client			
list client business name:						FEIN:			
Address of principal place						Insurance			

Name and title
(please print):

Date:

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any

amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704, Call

800-922-2689 (toll-free), 503-378-3272, or Oregon Emergency Response, 800-452-0311 (toll-free), on nights and weekends.

Worker's

weekly wage: \$

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.

ZIP:

of business (not P.O. Box):

Street address from which

worker is/was supervised:

Were other workers injured? \( \subseteq \text{Yes} \subseteq \text{No} \)

Date worker

returned to work:

Address where event occurred:

Date employer

knew of claim:

Employer

signature:



### A Guide for Workers Recently Hurt on the Job

#### How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete Form 801, "Report of Job Injury or Illness," available from your employer and Form 827, "Worker's and Health Care Provider's Report for Workers' Compensation Claims," available from your health care provider.

### How do I get medical treatment?

- You may receive medical treatment from the health care provider of your choice, including:
  - > Authorized nurse practitioners
  - Chiropractic physicians
  - Medical doctors
  - Naturopathic physicians
  - Oral surgeons
  - Osteopathic physicians
  - > Physician assistants
  - > Podiatric physicians
  - > Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

#### Are there limitations to my medical treatment?

- Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work. Check with your health care provider about any limitations that may apply.
- If your claim is denied, you may have to pay for your medical treatment.

## If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your jobrelated injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

### What if I have questions about my claim?

- The insurance company or your employer should be able to answer your questions.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

Ombudsman for Injured Workers: An advocate for injured workers

Toll-free: 800-927-1271

Email: oiw.questions@oregon.gov

Workers' Compensation Resolution Section

Toll-free: 800-452-0288

Email: workcomp.questions@oregon.gov

**Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?** You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

### 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	<b>":</b>		
Employee count:			
Current network:			

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 Insurance Group® are registered service marks of Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 1251-ALT-CA (06/20)

