# 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.

*Insert self-insured employer and insurer name, address, phone number, and service company, if any.*

# 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 claim with the insurance company, do not sign the signature line.** Your employer will give you a copy.

| Date of injury or illness: | Date you left work: | Time you began work on day of injury: ☐ a.m. ☐ p.m. | Regularly scheduled days off: ☐☐☐☐☐☐☐ M T W T F S S | DEPT USE: |
|---|---|---|---|---|
| Time of injury or illness: ☐ a.m. ☐ p.m. | Time you left work: ☐ a.m. ☐ p.m. | Check here if you have more than one job: ☐ | | Emp |
| | | | | Ins |
| What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐Left ☐Right | | | | Occ |
| | | | | Nat |
| What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials) | | | | Part |
| | | | | Ev |
| | | | | Src |
| | | | | 2src |

***Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.***

| Your legal name: | Language preference: | Birthdate: | 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 treated you for the injury or illness you are now reporting: |
|---|---|
| Were you hospitalized overnight? ☐ Yes ☐ No | |
| Were you treated in the emergency room? ☐ Yes ☐ No | |

**By my signature,** I am making a claim for workers' compensation benefits. The above information is true to the best of my knowledge and belief I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(l)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization.

**I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325.**

| Worker signature: | Completed by (please print): | Date: |
|---|---|---|

## Employer

Complete the rest of this form and give a copy of the form to the worker. Even if the worker does not want to file a claim, keep a copy of this form.

| Employer legal business name: | Phone: | FEIN: |
|---|---|---|
| If worker leasing company, list client business name: | | Client FEIN: |
| Address of principal place of business (not P.O. Box): | | Insurance policy no.: |
| Street address from which worker is/was supervised: ZIP: | | Nature of business in which worker is/was supervised: |
| Address where event occurred: | | |

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

| Were other workers injured? ☐ Yes ☐ No | | | OSHA 300 log case no: | |
|---|---|---|---|---|
| Date employer knew of claim: | Date worker returned to work: | Worker's weekly wage: $ | Date worker hired: | If fatal, date of death: |

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 signature: | 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.

*Insert self-insured employer and insurer name, address, phone number, and service company, if any.*

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| Date of injury or illness: | Date you left work: | Time you began work on day of injury: ☐ a.m. ☐ p.m. | Regularly scheduled days off: ☐M ☐T ☐W ☐T ☐F ☐S ☐S | DEPT USE: |
|---|---|---|---|---|
| Time of injury or illness: ☐ a.m. ☐ p.m. | Time you left work: ☐ a.m. ☐ p.m. | Check here if you have more than one job: ☐ | | Emp |
| | | | | Ins |
| What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐Left ☐Right | | | | Occ |
| | | | | Nat |
| What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials) | | | | Part |
| | | | | Ev |
| | | | | Src |
| | | | | 2src |

***Information ABOVE this line; date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.***

| Your legal name: | Language preference: | Birthdate: | 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 treated you for the injury or illness you are now reporting: | |
| Were you hospitalized overnight? ☐ Yes ☐ No | | | |
| Were you treated in the emergency room? ☐ Yes ☐ No | | | |

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| If worker leasing company, list client business name: | | Client FEIN: |
| Address of principal place of business (not P.O. Box): | | Insurance policy no.: |
| Street address from which worker is/was supervised: ZIP: | | Nature of business in which worker is/was supervised: |
| Address where event occurred: | | |

Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

| Were other workers injured? ☐ Yes ☐ No | | | OSHA 300 log case no: | |
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*Insert self-insured employer and insurer name, address, phone number, and service company, if any.*

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|---|---|---|---|---|
| Time of injury or illness: ☐ a.m. ☐ p.m. | Time you left work: ☐ a.m. ☐ p.m. | Check here if you have more than one job: ☐ | | Emp |
| What is your illness or injury? What part of the body? Which side? (Example: Sprained right foot) ☐Left ☐Right | | | | Ins |
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| What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials) | | | | Part |
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| 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 treated you for the injury or illness you are now reporting: | |
| Were you hospitalized overnight? ☐ Yes ☐ No | | | |
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| Street address from which worker is/was supervised: ZIP: | | Nature of business in which worker is/was supervised: |
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Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No

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DCBS | Consumer and Business Services
Workers' Compensation Division

# 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 job-related 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:** _____

**Employee count:** _____

**Current network:** ☐ Yes ☐ No





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