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.

VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 1 (Rev. 9/11)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name:	2. Business Name:
3. Mail Address: No. and Street / City / State / Zip	
4. Location (if different from Mail Address):	5. Telephone Number, Extension and Contact Person.:
6. Nature of Business (list principal products or service of concern):	7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No / 8. Federal ID No.:

EMPLOYEE

9. Name: First Name	Middle Initial	Last Name	10. Social Security No.:	11. Date of Birth:
12. Home Address: No. and Street		13. Home Phone No.:	14. Work Phone No:	15. Age:
City	State	Zip	16. Job Title:	17. Sex: ☐ M ☐ F

18. Wages $ / Per	Hours Per Day / Days Per Week	19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $	20. Was employee hired in VT? ☐ Yes ☐ No	21. Date of Hire

ACCIDENT

22. Date of Accident:	Accident Time: AM PM	Began Shift: AM PM	23. Location of Accident: Town or City / State

24. Machine, tool, object, motor vehicle or substance directly causing injury:

25. On employer's premises? ☐ Yes ☐ No If yes, name of department:

26. Describe what employee was doing: / Was this the employee's regular occupation? ☐ Yes ☐ No

27. How did accident occur? Describe events leading up to the accident:

INJURY

28. Describe the injury and the part of the body injured.

29. Was this a first-aid only injury: ☐ Yes ☐ No

30. Any Lost Time? ☐ Yes ☐ No	If yes, date disability began	Last date paid in full:	31. Employee returned to work? ☐ Yes ☐ No	If yes, date	Medical Only Incident: Yes ☐ No ☐

32. Did injury result in death? ☐ Yes ☐ No / If yes, date of death.

33. Name and address of Physician:

34. Name and address of Hospital: / Remained Overnight ☐ Yes ☐ No

INS

35. Insurance Company Named on Workers' Compensation Policy

Name in full: _____

Policy No.

35A. Claim Administrator

Company Name _____

Phone Number

Signed by: _____

Employer or Representative / Title / Date

Equal Opportunity is the Law

Mail to:

DOL Form 8 Rev. 9/11

Insurance Carrier Name: _____ State File No. _____

Insurance Carrier Address: _____ Ins. Co. File No. _____

Insurance Carrier City/State/Zip: _____ Date of Injury _____

Insurance Carrier Adjuster: _____

NOTICE OF INTENT TO CHANGE HEALTH CARE PROVIDER

Note: An employee has the right to change health care providers from the one suggested or assigned to them by their employer, **regardless** of the reasons for the change, at **any time** during the course of treatment after the first appointment.

Employee Name: _____

Address: _____

City/State/Zip: _____ Home Telephone: _____

E-mail Address: _____ Work Telephone: _____

I am changing my medical care for my work-related injury from the first treating health care provider selected by my employer to the provider of my choice.

FIRST TREATING PROVIDER

Name: _____

Address: _____

City/State/Zip: _____

NEW TREATING PROVIDER

Name: _____

Address: _____

City/State/Zip: _____

I am changing because:

- ☐ I would rather treat with my family health care provider.
- ☐ I believe another health care provider is better able to treat my symptoms.
- ☐ I have previously treated with another health care provider.
- ☐ Other (please describe below):

_____

This notice should be presented to the employer/insurance carrier prior to changing health care providers to fulfill the requirements of Vermont law, [21 V.S.A. § 640(b)]. Notice is not required for subsequent changes of provider after the first change of provider form is submitted.

_____

Print Employee Name

_____ _____

Employee Signature Date

VERMONT
DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, _____ , has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

_____

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- An injured employee MUST immediately notify his/her employer of an injury.
- The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.
- If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.
- Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.

ESTADO DE VERMONT

Responsabilidades de la Empresa Contratante & Indemnización por Accidentes Laborales (*Workers' Compensation*)

NOTIFICACIÓN A LOS EMPLEADOS

ESTA EMPRESA CONTRATANTE, _____,
HA CUMPLIDO CON LAS DISPOSICIONES DEL TÍTULO 21 DE LOS ESTATUTOS DEL ESTADO DE VERMONT, ANOTADAS EN LA § 687, ASEGURÁNDOSE BAJO UNA PÓLIZA DE SEGURO CONTRA ACCIDENTES LABORALES EMITIDA POR:

_____

(COMPAÑÍA DE SEGUROS)

EL EMPLEADO DE ESTA COMPAÑÍA TIENE DERECHO A SER INDEMNIZADO POR EL TIEMPO PERDIDO, GASTOS MÉDICO GENERADOS, INCAPACIDAD SUFRIDA O LA MUERTE, SI ÉSTOS FUESEN ATRIBUIBLES A UNA LESIÓN RELACIONADA CON SU TRABAJO.

- **LA LESIÓN SUFRIDA TENDRÁ QUE SER REPORTADA INMEDIATAMENTE A LA COMPAÑÍA CONTRATANTE POR EL EMPLEADO LESIONADO.**

- **LA EMPRESA CONTRATANTE TENDRÁ QUE REMITIR UNA RECLAMACIÓN A NOMBRE DEL EMPLEADO Y PRESENTAR EL PRIMER REPORTE DE UNA LESIÓN EN EL FORMULARIO CORRESPONDIENTE (FORMULARIO 1) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES (*THE DEPARTMENT OF LABOR AND INDUSTRY*), POR CONCEPTO DE CUALQUIER LESIÓN QUE REQUIERA ATENCIÓN MÉDICA O QUE RESULTARA EN LA PÉRDIDA DE TIEMPO LABORAL. LA EMPRESA TENDRÁ QUE REMITIR DICHA RECLAMACIÓN Y REPORTE DENTRO DE 72 HORAS DESPUÉS DE HABER RECIBIDO NOTIFICACIÓN DE LA LESIÓN. LA EMPRESA CONTRATANTE TAMBIÉN LE TENDRÁ QUE PROPORCIONAR UNA COPIA DEL FINALIZADO FORMULARIO 1 AL EMPLEADO LESIONADO Y A LA COMPAÑÍA DE SEGUROS.**

- **SI LA EMPRESA CONTRATANTE NO CUMPLIERA CON LA PRESENTACIÓN DEL PRECITADO PRIMER REPORTE, EL EMPLEADO PODRÁ LLENAR Y REMITIR EL FORMULARIO 5 TITULADO *NOTIFICACIÓN DE LESIÓN Y RECLAMACIÓN PARA INDEMNIZACIÓN* (*NOTICE OF INJURY AND CLAIM FOR COMPENSATION—FORM 5*) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES DENTRO DE SEIS MESES, CONTADOS A PARTIR DE LA FECHA DE LA LESIÓN.**

- **SI DESEA INFORMACIÓN REFERENTE A LOS DERECHOS Y BENEFICIOS DEL EMPLEADO LESIONADO VISITE EL *WEB SITE* DE SEGURO CONTRA ACCIDENTES LABORALES http://www.state.vt.us/labind/wcindex.htm O SÍRVASE LLAMAR AL (802) 828-2286**

FORMULARIO 31 2/03

NOTICE

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ADVERTENCIA

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