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.

First Report of Injury

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

SEE INSTRUCTIONS ON REVERSE SIDE

www.vwc.state.va.us

Reason for filing: _____
VWC Jurisdiction Claim #: (If assigned) _____
Claim Administrator File#: _____

Employer

Employer's Legal Name	Federal Employer Identification Number (FEIN)
Employer's Mailing Address	
Name/FEIN of Entity on Policy	Nature of Business
Name and Address of Insurer or Self-Insurer for this Claim	Policy Number

Time and Place of Accident

Location where accident occurred	Date of injury	Hour of injury ☐ a.m. ☐ p.m.
Date injury or illness reported	If fatal, give date of death	If fatal, give marital status ☐ Single ☐ Divorced ☐ Married ☐ Widowed
	If fatal, give number of dependent children	

Injured Worker

Name of Injured Worker	Phone Number	Injured Worker ID Number
Injured Worker's mailing address		Type of ID ☐ Social Security No. ☐ Employment Visa ☐ Green Card ☐ Passport No. ☐ Unknown
Occupation at time of injury or illness	Date of birth	Sex ☐ Male ☐ Female

Nature and Cause of Accident

Machine, tool, or object causing injury or illness
Describe fully how injury or illness occurred
Describe nature of injury, occupational disease, or illness, including body parts affected

Signatures

Submitter (name, signature, title)	Date	Phone number
Submitter's Address		

First Report of Injury

Filing Instructions

The Virginia Workers' Compensation Act requires that **ALL** injuries occurring in the course of employment be reported to the Commission pursuant to Va. Code §65.2-900.

Employer

The employer is responsible for accurately completing all sections of this form when an employee is injured. It should be typed or legibly printed, signed, and dated by the preparer. Send the original form to the claim administrator for the insurance company who provided insurance coverage on the date of the occurrence. The claim administrator will report this information to the Commission. Contact your workers' compensation insurance provider for additional information.

Claim Administrator

Claim administrators who are EDI enabled will use the information contained on the paper form and submit electronic data to the Commission.

Claim administrators who are NOT EDI enabled must immediately file the completed form with the Commission. Please note: EDI is mandatory no later than June 30, 2009, after which time paper reports will no longer be accepted. Until you are in EDI production, mail the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220. At the top of the form, use a numerical code (1-7) to indicate the reason for filing the form for accidents meeting one of the filing criterion.* If none of the criteria apply, you must still report the accident, but may use either Form 45A or this form to do so. (Leave "reason for filing" blank in such a case.)

For questions or assistance in completing the form, please contact the Commission toll-free at 877-664-2566.

*Criteria for filing are: (1) lost time exceeds seven days; (2) medical expenses exceed $1,000.00; (3) compensability is denied; (4) issues are disputed; (5) accident resulted in death; (6) permanent disability or disfigurement may be involved; and (7) a specific request is made by the Virginia Workers' Compensation Commission.

Form VWC1

WORKERS' COMPENSATION NOTICE

The employees of this business are covered by the Virginia Workers' Compensation Act. In case of injury by accident or notice of an occupational disease:

THE EMPLOYEE SHOULD:

1. Immediately give notice to the employer, in writing, of the injury or occupational disease and the date of accident or notice of the occupational disease.

2. Promptly give to the employer and to the Virginia Workers' Compensation Commission notice of any claim for compensation for the period of disability beyond the seventh day after the accident. In case of fatal injuries, notice must be given by one or more dependents of the deceased or by a person in their behalf.

3. In case of failure to reach an agreement with the employer in regard to compensation under the act, file application with the Commission for a hearing within two years of the date of accidental injury or first communication of the diagnosis of an occupational disease.

4. If medical treatment is anticipated for more than two years from the date of the accident and no award has been entered, the employee should file a claim with the Commission within two years from the date of the accident.

NOTE: The employer's report of accident is not the filing of a claim for the employee. The voluntary payment of wages or compensation during disability, or of medical expenses, does not affect the running of the time limitation for filing claims. An award based on a voluntary agreement must be entered or a claim filed within two years; one year in death cases.

THE EMPLOYER SHOULD:

1. At the time of the accident, give the employee the names of at least three physicians from which the employee may select the treating physician.

2. Report the injury to the Commission through your carrier or directly to the Commission.

3. Accurately determine the employee's average weekly wage, including overtime, meals, uniforms, etc.

Questions may be answered by contacting the Commission. A booklet explaining the Workers' Compensation Act is available without cost from:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, Virginia 23220

1-877-664-2566
vwc.state.va.us

Every employer within the operation of the Virginia Workers' Compensation Act MUST POST THIS NOTICE IN A CONSPICUOUS PLACE in his place of business.

NOTICIA SOBRE COMPENSACIÓN LABORAL

Los empleados de ésta empresa estan cubiertos por la Ley de Compensacion Para Los Trabajadores de Virginia (Virginia Workers' Compesation Act). En caso de lesion por accidente o aviso de una enfermedad ocupacional:

EL EMPLEADO DEBE:

1. Dar aviso inmediato, por escrito, al empleador sobre lesiones o enfermedad ocupacional y dar la fecha del accidente o del aviso de la enfermedad ocupacional.

2. Dar aviso inmediato al empleador y a "Virginia Workers' Compensation Commission" de cualquier reclamo por compensación por periodos de incapacidad de más de siete dias despues del accidente. En caso de lesiones fatales, el aviso debe ser dado por uno o mas de los dependientes o herederos del difunto o las personas que los representan.

3. Presentar una solicitud a la Comisión para una audencia dentro de dos años de la fecha de la lesión por accidente or de la primera comunicación del diagnóstico de enfermedad ocupacional, si no llega a un acuerdo con el empleador en relacion al pago de compensación bajo la Ley.

4. Presentar una solicitud a la Comisión dentro de los dos años de la fecha del accidente, si el tratamiento médico es anticipado por mas de dos años de la fecha del accidente y el empleado no ha récibido una orden de la Comisión.

NOTA: El reporte de accidente del empleador no es la presentacion del reclamo del empleado. El pago voluntario sueldos o compensacion durante la incapacidad o de los gastos medicos, no afecta el transcurso de la limitación del tiempo para presentar reclamos. La Comisión debe de dar una orden cubriendo acuerdos voluntarios y si no, una reclamación debe de ser presentada por el empleado dentro de los dos anos del accidente; un año en caso de fallecimiento.

EL EMPLEADOR DEBE:

1. Al momento del accidente, dar al empleado los nombres de por lo menos tres médicos, de los cuales el empleado puede escoger un médico para su tratamiento.

2. Reportar las lesiones a la Comision a traves de su representate o directamente a la Comisión.

3. Determinar exactamente el salario semanal del empleado, incluyendo sobretiempo, comidas, uniformes, etc.

Preguntas pueden ser contestadas llamando a la Comision. Un folleto explicando la Ley de Compensación Para Los Trabajadores esta disponible sin costo de:

THE VIRGINIA WORKERS' COMPENSATION COMMISSION
1000 DMV Drive
Richmond, VA 23220
1-877-664-2566
vwc.state.va.us

Cada empleador dentro de la operacion de la Ley de Compensacion Para Trabajadores en Virginia, DEBE DE EXPONER ESTE AVISO EN UN LUGAR VISIBLE, en la empresa o lugar de negocios.

Report of Minor Injuries

Submit to: Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

45 - A

See instructions on the reverse of this form.

Insurer

Name of insurer or self-insurer	Period covered From ___/___/___ To ___/___/___.		
Address	Insurer code	Insurer location	Date filed
	Contact Person		Phone number

Payments

NOTE: If this accident has been previously reported on Form 45A, pl ace an "X" in the box by the entry.

☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost
☐	Name of employee	Social Security Number	Date of accident
	Address of employee	Name and address of employer	
		Employer Tax Identification Number	Monthly medical cost

FILING INSTRUCTIONS
(Instructions Updated 09/01/07)

Report of Minor Injuries
VWC Form No. 45A

1. This form is used to report minor injuries which do not: a) result in lost time of more than seven days; b) involve more than $1,000 in medical costs; or c) involve a fatality, permanent disability, or disfigurement.* The information you provide is used both to report on medical costs and provides proper notification to injured employees of their rights under the Virginia Workers' Compensation Act.

2. The insurer should provide the information at the top of the form and the Report of Minor Injuries (VWC Form No. 45A) should be submitted to the Commission on a monthly basis.

3. Type or legibly print all information on the form for each employee including, the social security number, accident date and the federal tax identification number for all employers.

4. Place a check in the box to the left of the employee's name whenever the accident has been previously reported to the Commission as a Minor Injury Claim and additional medical costs were incurred, but the total medical costs have not exceeded $1,000.

5. If this is the initial reporting of a claim, and there has been no medical cost, place a zero ($0) in the box for monthly medical costs. It is not necessary to report zero ($0) medical costs each month after the initial reporting of the injury.

6. **Forms**: Additional copies of this form are available without cost by writing to the Commission. Address your inquiry to "Forms" at the listed Virginia Workers' Compensation Commission address. Please note that any alternate versions of the form you develop yourself require prior approval by the Commission.

7. **Electronic Filing**: The Report of Minor Injuries (VWC Form No. 45A) can be filed electronically through the Commission's website, www.vwc.state.va.us and selecting "Electronic Filing Services". If you are interested in the batch processing method, please contact our "Information Systems Department" at (804) 367-2084 or in writing. Please provide a brief description of your current data processing and communication capabilities.

8. For questions or assistance with completing this form, please contact the First Reports Unit at (804) 367-0072 or the Commission's toll free number (1-877) 664-2566.

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*More specifically, the seven situations in which you should NOT use this form, and should instead file an Employer's Accident Report are when (1) lost time exceeds seven days, (2) medical expenses exceed $1,000, (3) compensability is denied, (4) issues are disputed, (5) the accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia Workers' Compensation Commission.

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT.

Commonwealth of Virginia
Virginia Workers' Compensation Commission
1000 DMV Drive, Richmond, Virginia 23220

*VWC Claim No.*_____

Case of _____

SUPPLEMENTARY REPORT

If Employer's Accident Report did not show that the injured had returned to work, an Employer's Supplemental Report of injury should he completed and filed immediately after return to work of the employee. In the event of the death of the employee, this report should be filed immediately.

1	Name of Employer				
2	Office Address: No. and St.			City or Town	State
3	Insured by: Name of Company				
4	Name of Injured (in full)	Last		First	Middle Name
5	Present address: No. and St.			City or Town	State
6	Date of Injury	Date	Day of Week	Hour of Day	AM or PM
7	Date Disability began			Date	AM or PM
8	Has injured returned to work?			IF SO, date and hour	AM or PM
9	Is injured person earning same wages as before injury?			Yes or No	If not, explain
10	If disability has not terminated, state probable date of termination of disability				
11	Has injured died?			If so, date of death	AM or PM

NOTE: This form is not an agreement and its filing is not sufficient to terminate an outstanding award.

Date of this report	**Firm Name**
Signed by	**Official Title**

VWC#3A (Rev 9/1/99)