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 Alliance 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[®] and Great American Insurance Group[®] are registered service marks of Great American Insurance Company. © 2020 Great American Insurance Company. All rights reserved. 4642-ALT-1 (5/20)



GreatAmericanCaptive.com

Alternative Markets

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.

EMPLOYER'S FIRST REPORT OF INJURY OR DISEASE

Fatal Injuries: Employers subject to ch.102, Wis. Stats., must report injuries resulting in death to the Department and to their insurance carrier, if insured, within one day after the death of the employee. Non-Fatal Injuries: If the injury or occupational illness results in disability beyond the three-day waiting period, the employer, if insured, must notify its insurance carrier within 7 days after the injury or beginning of disability. Medical-only claims are to be reported to the insurance carrier only, not the Department. Electronic Reporting Requirement: All work-related injuries and illnesses resulting in compensable lost time, with the exception of fatalities, must be reported electronically to the Department via EDI or Internet by the insurance carrier or self-insured employer within 14 days of the date of injury or beginning of disability. Employer may fax claims for fatal injuries to the Imaging Fax Server number on this form.

Department of Workforce Development Worker's Compensation Division 201 E. Washington Ave., Rm. C100 P.O. Box 7901 Madison, WI 53707-7901 Imaging Server Fax: (608) 260-2503 Telephone: (608) 266-1340 http://www.dwd.wisconsin.gov/wc

e-mail: DWDDWC@dwd.wisconsin.gov

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Employee Name (First, Middle, Last)			Social Securit		Sex	Sex ⊐M□F		Employee Home Telepho () -					
Employee Name (First, Middle, Last) Employee Street Address Bitthdate	· ·				State		Zip Code		Occupation				
Birthdate Date of Hire)	Co	County and State Where Accident or Exposure Occurred?										
Employer Name	, in the second s	WIU		nent Ins. Acct No.	Self-Insured? Nature of Bu				siness (Specific Product)				
Employer Mailing Address			City		State	State Zip Code				Employer FEIN -			
Name of Worker's Compensation Inst								Insurer FEIN -					
Name and Address of Third Party Administrator (TPA) Used by the Insurance Company or Self-Insured Employer													
Wage at Time of Injury Specify per \$ Per:	r hr., wk., mo	., yr.		n Addition to Wag Check Box(es) if Employee Receive		oom	m No. of Days/wk						
Is Worker Paid for Overtime?	Yes 🗆 No	lf	Yes Aff	er How Many Ho	ours of Wc	ork Poi	r Maak2						
Is Worker Paid for Overtime? Yes No If Yes, After How Many Hours of Work Per Week? For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.													
No. of Weeks: Gross Amount Excluding Tips: \$ If Piece-Work, No. of Hrs. Excluding Overtime:													
Start Time Hours Per Day Hours Per Week Days Per V													
Is Worker Paid for Overtime?	e When Inju	red:	:	🗌 АМ 🗌 РМ									
Type of Work at Time of Employee's Injury: Number of Full-Time Employees Doing The Same Work Part-Time Are there Other Part-Time Workers Doing the Same Work Employment With the Same Schedule? Information: Yes													
Injury Date Time of Injury			Worked	Date Employe	r Notified	🗌 Da	te Returne	ed to Wo	rk				
: AM :	PM						timated Da		eturn				
Did Injury Cause Death? Date of De			i his a Lo ipensable	st Time or Other Injury?	1		r Because						
			🗌 Ye	s 🗌 No	Abuse Safety Devices Obey Rules								
Did Injury Cause Death? Date of De Yes No Was Employee Treated in an Emerg Name and Address of Treating Prace	gency Room	?	Yes 🔲	No Was Employ	ee Hospita	alized (Overnight	as an I	n-Patient?				
Case Number from the OSHA Log:	auoner and	nus	pital:										
Case Number from the OSHA Log: Injury Description - Describe Activities of Employee When Injury or Illness Occurred and What Tools, Machinery, Objects, Chemicals, Etc. Were Involved.													
What Happened to Cause This Injury of	or Illness? (D	escri	ibe How T	he Injury Occurred	d)								
What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)													
Report Prepared By W	Vork Phone N	lumb	er	Position					Date	e Signed			
() -								Date Signed				
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EMPLOYER AND INSURANCE CARRIER INSTRUCTIONS

The employer must complete all relevant sections on this form and submit it to the employer's worker's compensation insurance carrier or third party claim administrator within seven (7) days after the date of a work-related injury which causes permanent or temporary disability resulting in compensation for lost time. The employer's insurance carrier or the third-party claim's administrator may request that this form also be used to immediately report any injury requiring medical treatment, even though it does not involve lost work time.

For any work injury resulting in a **fatality**, the employer must also submit this form directly to the Department of Workforce Development **within 24 hours of the fatality**.

An employer exempt from the duty to insure under s. 102.28, Wis. Stats., and an insurance carrier administering claims for an insured employer are required to submit this form to the Department of Workforce Development within 14 days of the date of work injury.

MANDATORY INFORMATION

In order to accurately administer claims, each of the following sections of this form must be completed. The First Report of Injury will be returned to the sender if the mandatory information is not provided.

Employee Section: Provide all requested information to identify the injured employee. If an employee has multiple dates of employment, the "Date of Hire" is the date the employee was hired for the job on which he or she was injured.

Employer Section: Provide all requested information to identify the injured worker's employer at the time of injury. Provide the name and Federal Employer Identification Number (FEIN) for the insurance carrier or self-insured employer responsible for the worker's compensation expenses for this injury. Also identify the third party claim administrator, if one is used for this claim.

Wage Information Section: Provide the information requested regarding the injured employee's wage and hours worked for the job being performed at the time of injury.

Injury Information Section: Provide information regarding the date and time of injury. Provide a detailed description of the injury, including part of the body injured, the specific nature of the injury (i.e., fracture, strain, concussion, burn, etc.) and the use of any objects or tools (i.e., saw, ladder, vehicle, etc.) that may have caused the injury. Provide the name of the person preparing this report and the telephone number at which they may be reached, if additional information is needed. This form was designed to include information required by OSHA on form 301. If this section is completed and retained, the employer will not have to complete the OSHA 301 form.

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	Employee Name (First, Middle, Last)							Social Security	· I_						bloyee Home Telephone No.			
ЕМРLOYE	Employee Street Address C						City			State			<u>И</u>) - Occupation			
ШP							-											
11	Birthdate	ld St	State Where Accident or Exposure Occurred?															
	Employer Nam	e		yme	nt Ins. Acct No. Self-Insured? Nature of Business (Specific Pr							ic Product)						
		<u> </u>		-		🗌 Yes 🗌 No												
ΥEκ	Employer Maili	ng Addres	SS			Stat	e	Zip (Code			Employer FEIN						
ЕМРСОТЕК	Name of Worke	er's Comp	ensation I	Self-Insure	elf-Insured Employer				·····					Insurer FEIN				
Ĭ	Name and Add																	
	Name and Add	ress of 1r	nird Party A	Administra	ator (TP.	A) Used by	/ the	e Insurance Com	nsurance Company or Self-Insured Employer							TPA FEIN		
	Wage at Time	of Injury	Specify	per hr., w	k., mo.,	yr., etc.	ln /	Addition to Wage	es,	ПМ	eals	No.	of N	leals/v	vk.			
	\$		Per:					eck Box(es) if ployee Receive	d					ays/wl eekly A				
2															ππ. φ			
2	Is Worker Paid for Overtime? Yes No If Yes, After How Many Hours of Work Per Week? For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work,																	
MA												eeks W	orke	ed in t	he Same I	Kind of Work,		
	and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks. No. of Weeks: Gross Amount Excluding Tips: \$ If Piece-Work, No. of Hrs. Excluding Overtime:										rtime:							
							ę	Start Time		Но	urs Pe	r Day		Hours F	Per Week	Days Per Week		
D	Employee's	Usual W	ork Sched	lule Whe	n Injure	ed: :	[🗌 АМ 🔲 РМ										
\$			Full-Time t Time of															
	Part-Time	1					s Do	oing the Same	Work		Numł	er of F	ull-'	Time	Employee	s Doing The		
	Employment					Туре			p.oyov	e Benig Ine								
	Information: Injury Date	Time of	Yes [<u>No</u>		s <u>, how mar</u> ay Worked		Data Employa	r Notif	lad								
	injury Date		AM :	РМ	Lasi D	ay worked	4		Date Employer Notified									
5	Did Injury Caus							t Time or Other	er Did Injury Occur Because of:									
	Yes No	□ Yes □ No Compensable												ire to Use				
	Was Employee	e Treated	l in an Em	ergency	Room?				/ee Ho							Obey Rules		
	Name and Add				er and H	lospital:						-						
	Case Number	from the	OSHA Lo	g: /ities of Fi	mnloves	Allen Ini		or Illness Occurre	ed and		t Tool	e Machi	iner		cte Cham	icale Etc. More		
	Involved.				npioyoe	2 THIST HIJ	ary C		ou ant	a v v 110	. 1008	5, Watili	101)	, obje		10410, 110. 99616		
	What Happened	d to Cause	e This Iniu	rv or lline	ss? (De	scribe How	/ Th	e Injury Occurre	d)									
				,					,									
	What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)																	
	Report Prepare	d By		Work Pl	none Nu	Imber		Position							Dat	e Signed		
													-					
	WKC-12 (R. 02)	/2009)	S		PORT		TE	LY - DO NOT '		FOR	MEC			ORT				
		2000)	0				ST E		v w Ai I		-1716-6			ONI	Sec. Sec.			

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Department of Workforce Development Worker's Compensation Division

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ΥEE	Employee Nam	S	Social Security	al Security Number S			1 🗆 F	Em	mployee Home Telephone No.) -							
EMPLOYEE	Employee Stre	et Addres	S		City			State			Zip Code		Occupati	Occupation		
Π	Birthdate	d State	State Where Accident or Exposure Occurred?													
	Employer Nam				WI	Unemploy	rment	Ins. Acct No.		nsure ⁄es [_		Nature	ness (Speci	ness (Specific Product)		
ידבא	Employer Maili	ng Addres	S			City	i	State Zip Code -					Employe	Employer FEIN -		
ЕМРСОТЕК	Name of Worke	ər's Comp	ensation I	elf-Insured	l Emp	loyer	•	I			Insurer F	Insurer FEIN -				
I	Name and Add	ress of Th	ird Party /	Administra	ator (TPA) Used by	the In	surance Com	pany (TPA FEI	TPA FEIN -					
Wage at Time of Injury Specify per hr., wk., mo., yr., etc. In Addition to Wages, Check Box(es) if Room \$ Per: Employee Received: Tips										No. of	o. of Meals/wk. o. of Days/wk vg. Weekly Amt. \$					
NO N	ls Worker Pai	id for Ove	ertime? [🗌 Yes [] No	lf Yes, Al	fter H	ow Many Ho	ours o	of Wo	rk Per	Week?				
	Is Worker Paid for Overtime? Yes No If Yes, After How Many Hours of Work Per Week? For the 52 Week Period Prior to the Week the Injury Occurred, Report Below the Number of Weeks Worked in the Same Kind of Work, and the Total Wages, Salary, Commission and Bonus or Premium Earned for Such Weeks.															
2	No. of Weeks: Gross Amount Excluding Tips: \$ If Piece-Work, No. of Hrs. Excluding Overtime:															
	Start Time Hours Per Day Hours Per Week Days Per Week															
	Employee's Usual Work Schedule When Injured: : AM PM															
	Employer Type o															
	Type of Work at Time of Employee's Injury: Number of Full-Time Employees Doing The Same Work Part-Time Are there Other Part-Time Workers Doing the Same Work Employment With the Same Schedule? Information: Yes											es Doing The				
	Injury Date	Time of I				y Worked		Date Employe	Employer Notified Date Returned to Work							
			M :	PM					_							
	Did Injury Caus ☐ Yes ☐ No		Date of	f Death		as This a L Impensabl		ime or Other rv?							Failure to	
						🗌 Y	′es 🗌	No Abuse Safety						y Devices Obey Rules		
	Was Employee Name and Ado						No	Was Employ	ee Ho	ospita	lized C	Overnight	as an	In-Patient?	Yes No	
	Case Number		-			opilal.										
	Injury Descript	tion - Des	cribe Activ	vities of E	mployee	When Inju	ry or l	Ilness Occurre	ed and	d Wha	t Tools	, Machine	ery, Ob	jects, Chem	icals, Etc. Were	
		d to Cours	This Iniv	n or lline	002 (Do-	oribo Llovi	Tha		47							
	What Happened to Cause This Injury or Illness? (Describe How The Injury Occurred)															
	What Was The Injury or Illness? (State the Part of Body Affected and How It Was Affected)															
Report Prepared By Work Phone ()						nber	Position	Position					Dat	Date Signed		
	WKC-12 (R. 02/	/2009)	S	END RE	PORT II	MMEDIA	TELY	- DO NOT	WAIT	FOR	MED	ICAL RE	POR	T		

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