

**GREAT AMERICAN INSURANCE COMPANY
TEXAS NONSUBSCRIBER CLAIMS OFFICE
P.O. BOX 2309
ADDISON, TX 75001-2309
PHONE: 972-930-9493 OR TOLL FREE 866-930-9493
FAX: 972-930-9479 Or Email: txnonsubscriberclaims@gaic.com**

ACCIDENT REPORTING PROCEDURES

When an injury (or alleged injury) occurs:

- See that the injured employee receives **prompt medical attention**, and complete the initial “**Medical Treatment Authorization**” form, including the “Drug/Alcohol Screen” section. The form is sent with the injured employee to the medical facility.
- Send the employee to an occupational accident medical facility.

Immediately upon notification of an incident:

- Have the injured employee complete and sign the **Employee Statement of Injury** form.
- Have the employee sign the **Medical Record Release Authorization**.
- Complete the **Supervisor’s Incident Report**.

Review the forms and make sure they are complete, signed and have your Company Name listed. Make copies of the attached forms for your records and future use.

Immediately upon completion of the forms, **fax OR email** them to:

FAX: (972) 930-9479 or E-mail address: txnonsubscriberclaims@gaic.com

**Accidents resulting in death or severe injury should be reported immediately by telephone.
Call 972-930-9493 or Toll free 1-866-930-9493.**

After Great American Insurance Company has received the completed notice and forms, you will be sent an acknowledgement letter. All medical bills should be submitted to Great American Insurance Company for approval and audit prior to payment.

***If you should have any questions concerning a claim, do not hesitate to call us at
1-866-930-9493 between 8:00 A.M. and 5:00 P.M. Monday through Friday.***

GREAT AMERICAN INSURANCE COMPANY

Claims Kit

Includes:

Accident Reporting Procedures

FORMS:

EMPLOYEE STATEMENT OF INJURY

SUPERVISORS INCIDENT REPORT

WITNESS STATEMENT

MEDICAL TREATMENT AUTHORIZATION

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

MEDICAL RECORDS RELEASE AUTHORIZATION

DECLINE MEDICAL TREATMENT FORM

REVIEW FOR COMPLETENESS

FAX OR EMAIL REPORT NOTICES TO:

GREAT AMERICAN INSURANCE COMPANY

FAX: (972) 930-9479

Or

EMAIL: txnonsubscriberclaims@gaic.com

Should you have any questions regarding any of these forms, please contact our office at (866) 930-9493 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

EMPLOYEE STATEMENT OF INJURY

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE
Fax or Email this completed form to GREAT AMERICAN INSURANCE COMPANY (972) 930-9479 or
txnonsubscriberclaims@gaic.com

EMPLOYER INFORMATION: _____
ADDRESS: _____ City: _____ State TX Zip: _____
PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

EMPLOYEE INFORMATION:

NAME _____ D.O.B. ____ / ____ / ____ SOCIAL SECURITY NO. _____
HOME ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE (_____) _____
OF DEPENDENTS (IF ANY) _____ MARITAL STATUS _____ GENDER MALE FEMALE
PREFERRED LANGUAGE IF OTHER THAN ENGLISH _____

INJURY INFORMATION

DATE OF INCIDENT ____ / ____ / ____ TIME OF INCIDENT ____ A.M. P.M. DAY OF WEEK _____ TIME WORKSHIFT STARTED ____ A.M. P.M.

DATE I REPORTED INJURY TO MANAGER ____ / ____ / ____ TIME REPORTED _____ A.M. P.M.

ADDRESS WHERE INJURY OCCURED _____ CITY _____

STATE _____ ZIP _____ PHONE (_____) _____ FAX (_____) _____

EXACT AREA WHERE INJURED _____

DESCRIBE EQUIPMENT INVOLVED (IF ANY) _____

DESCRIBE WHAT YOU WERE DOING AT TIME OF INCIDENT _____

DESCRIBE FULLY HOW THE INCIDENT OCCURRED _____

WAS A SAFETY DEVICE APPLICABLE? YES NO WAS IT USED? YES NO IF YES INDICATE THE DEVICE APPLICABLE _____

DESCRIBE NATURE OF INJURY _____

BODY PART(S) INVOLVED _____

HAVE YOU HAD A SAME OR SIMILAR INJURY BEFORE? YES NO IF YES, GIVE DETAILS _____

I, _____ (Employee), the undersigned herewith CERTIFY that the foregoing statements and answers on this form are complete and true, and that no information has been omitted, and that I made such statements and answers of my own free will. I understand that my Employer does not carry Workers' Compensation insurance, and furthermore, that any payments to me or anyone else for expenses in connection with this incident and resulting in injury is not an admission of liability on the part of my Employer.

I authorize direct payment to medical providers and others rendering services in connection with this claim.

Employee Signature _____ Witness _____ Date _____

Translated by (if applicable) _____ Date _____

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Great American Insurance Company, Texas Nonsubscriber Claims Office - P O BOX 2309, Addison, TX 75001-2309 (866) 930-9493, FAX (972) 930-9479
Email: txnonsubscriberclaims@gaic.com

Great American Insurance Group, 301 East Fourth Street, Cincinnati, Ohio 45202

REVISION CLAIM FORMS (01-12)

SUPERVISORS INCIDENT REPORT

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER

Fax or Email this completed form to GREAT AMERICAN INSURANCE COMPANY(972) 930-9479 or
txnonsubscriberclaims@gaic.com

EMPLOYER NAME: _____	Policy# _____	
LOCATION: (If different from above) _____	LOCATION NO.: _____	
DEPARTMENT: _____	JOB TITLE: _____	DATE OF HIRE: ____/____/____
SCHEDULED DAYS/WEEK: _____	SCHEDULED HOURS/DAY: _____	HOURLY RATE: \$ _____
TIME LOST FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	FIRST DAY OF LOST TIME: ____/____/____	
DATE RETURNED TO <input type="checkbox"/> FULL <input type="checkbox"/> MODIFIED / DUTY: ____/____/____		

EMPLOYEE INFORMATION:

NAME: _____ SOCIAL SECURITY NO: _____
HOME ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____ PHONE: (____) _____
GENDER MALE FEMALE PREFERRED LANGUAGE IF OTHER THAN ENGLISH: _____

BASIC INJURY INFORMATION

DATE OF INCIDENT: ____/____/____ DAY OF WEEK: _____ TIME OF INCIDENT: _____ A.M. P.M.
DATE REPORTED INCIDENT: ____/____/____ DAY OF WEEK: _____ TIME REPORTED INCIDENT: _____ A.M. P.M.
NAME OF SUPERVISOR WHEN INJURY OCCURRED: _____ CONTACT PHONE #: (____) _____
DESCRIBE NATURE OF THE EMPLOYEE'S INJURY: _____
BODY PART(S) INVOLVED: _____
DESCRIBE EQUIPMENT INVOLVED (IF ANY): _____

WITNESS INFORMATION (IF NONE PLEASE INDICATE NONE)

NAME OF WITNESS: _____ HOME PHONE: (____) _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMPLOYEE? YES NO TITLE: _____ DEPT: _____ WORK PHONE: (____) _____
NAME OF WITNESS: _____ HOME PHONE: (____) _____
HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
EMPLOYEE? YES NO TITLE: _____ DEPT: _____ WORK PHONE: (____) _____

MEDICAL PROVIDER

NAME OF CLINIC/HOSPITAL/PHYSICIAN: _____ PHONE: _____
IF NOT A DESIGNATED PROVIDER, PLEASE COMPLETE THE FOLLOWING -
ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

SIGNATURE OF SUPERVISOR/MANAGER COMPLETING REPORT

Supervisor/Manager Name - Printed
X

Supervisor/Manager Signature

Phone

Date

WITNESS STATEMENT

Fax or Email this completed form to GREAT AMERICAN INSURANCE COMPANY (972) 930-9479 or
txnonsubscriberclaims@gaic.com

EMPLOYER INFORMATION: _____
ADDRESS: _____ City: _____ State TX Zip: _____
PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

NAME OF WITNESS _____ HOME PHONE _____
HOME ADDRESS _____ CITY _____ STATE ____ ZIP _____
TITLE _____ DEPT. _____ WORK PHONE _____
DATE OF INCIDENT _____ TIME OF INCIDENT _____ A.M. ____ P.M. ____

THIS STATEMENT CONCERNS MY KNOWLEDGE OF THE ALLEGED INCIDENT.

1. NAME OF INJURED EMPLOYEE: _____
2. IF NOT EMPLOYEE, REASON FOR PRESENCE AT LOCATION: _____

3. ARE YOU RELATED TO INJURED EMPLOYEE? _____ HOW? _____
4. HOW LONG HAVE YOU KNOWN THIS EMPLOYEE? _____
5. PLEASE EXPLAIN IN DETAIL WHAT YOU KNOW ABOUT THIS INCIDENT: (NAME SPECIFIC INDIVIDUALS, OBJECTS OR EQUIPMENT)

6. DID YOU ACTUALLY SEE THE INCIDENT? _____ IF NOT, HOW DID YOU HEAR ABOUT IT? _____

7. DO YOU KNOW OF ANY OTHER INJURY, INCIDENT OR ILLNESS THAT THIS EMPLOYEE HAS HAD? _____ IF SO, EXPLAIN: _____

8. GIVE THE NAMES AND ADDRESSES OF ANY OTHER PERSONS WHO MIGHT KNOW ABOUT THIS INCIDENT:

9. ADDITIONAL COMMENTS: _____

I certify that the foregoing statements and answers on this form are complete and true, and that no information has been omitted.

Witness: _____ Signature _____ Verified by: _____ Signature _____
Date: _____ Date: _____
Translated By (If Applicable): _____ Date: _____

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

MEDICAL TREATMENT AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYER
Fax or Email this completed form to GREAT AMERICAN INSURANCE COMPANY (972) 930-9479 or
txnonsubscriberclaims@gaic.com

EMPLOYER INFORMATION: _____
ADDRESS: _____ City: _____ State TX Zip: _____
PHONE: (____) _____ FAX: (____) _____ Policy# _____
INJURED EMPLOYEE: _____ Social Security Number: _____

To: Approved Provider

The above referenced employee has reported sustaining an occupational injury/illness related to his or her employment. You are authorized to provide medically necessary treatment and/or prescription services for conditions related to the reported injury/illness.

Type of Injury _____

Your charges for medically necessary services will be paid directly by the Employer. To facilitate prompt payment, submit your billing document and a copy of the Report (physicians only) to:

**GREAT AMERICAN INSURANCE COMPANY
TEXAS NONSUBSCRIBER CLAIMS OFFICE
P O BOX 2309
Addison, Texas 75001**

Treatment and billing inquiries should be directed to **GREAT AMERICAN INSURANCE COMPANY**. at (866) 930-9493. For authorization to release medical records and other information relating to the above employee's occupational injury/illness, refer to Medical Records Release Authorization.

Drug / Alcohol Screen Required Yes No

If the above box is checked **YES**, the employee is required to submit to a drug/alcohol screen which is only for the *initial* examination and emergency treatment of the injury noted above. Please conduct a drug/alcohol screen for your panel of controlled substances and alcohol, in addition to treating the occupational injury/illness. The results of the drug/alcohol screen must be reported only to the *Employer*.

Supervisor/Manager Name - Printed

X _____
Supervisor/Manager Signature

Date

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

Please be advised that this employer does not carry workers' compensation insurance. If it becomes necessary to refer to another doctor for treatment or opinion, please furnish such information to us prior to the referral for further authorization. All bills for authorized medical treatment or any inquiries concerning authorization for treatment should be directed to:

Attn: GREAT AMERICAN INSURANCE COMPANY. Phone (866) 930-9493
TEXAS NONSUBSCRIBER CLAIMS OFFICE Fax (972) 930-9479
P O BOX 2309 EMAIL: txnonsubscriberclaims@gaic.com
Addison, TX 75001-2309

EMPLOYER INFORMATION: _____
ADDRESS: _____ City: _____ State TX Zip: _____
PHONE: (____) _____ FAX: (____) _____ Policy# _____

Name of Injured Employee: _____

1. Date of injury: _____ Date first treatment rendered: _____
2. Description of incident: _____
3. Initial complaints: _____

4. Diagnosis: _____
5. Nature, extent, degree, body location of injury: _____
6. Treatment prescribed and prognosis: _____
7. Medication prescribed: _____
8. Probable length of hospital confinement: (if applicable) _____
9. X-rays taken Yes No If yes, results: Positive Negative _____
10. Lab test Yes No Describe procedure and results: _____

11. Was there any evidence of a prior or pre-existing injury or illness? Yes No If yes, what condition and to what extent may it contribute to incapacity or recovery? _____

12. In an effort to help employees return to work after an injury/illness more quickly, a limited duty program is available.
This Employee May return to work today without restrictions
 May return to work today with restrictions as indicated below for _____ days
 May not return to work until _____

13. If restrictions are required on or off the job, please indicate below:
- | | |
|---|--|
| <input type="checkbox"/> No standing over ___ hours | <input type="checkbox"/> No lifting over ___ lbs. |
| <input type="checkbox"/> No work requiring depth perception/driving | <input type="checkbox"/> No stooping/bending/twisting |
| <input type="checkbox"/> No reaching over shoulder height | <input type="checkbox"/> No walking over ___ hours |
| <input type="checkbox"/> No use R/L hand/upper extremities | <input type="checkbox"/> No weight-bearing R/L foot |
| <input type="checkbox"/> No climbing over ___ hours | <input type="checkbox"/> Must use crutches/splint |
| <input type="checkbox"/> No pushing/pulling over ___ lbs. | <input type="checkbox"/> No operation of machines/equipment |
| <input type="checkbox"/> Keep wound clean, dry ___ days | <input type="checkbox"/> No exposure to (specify, e.g. dust, chemical) _____ |
- 14a. Released to restricted duty: _____, 20____. 14b. Released to regular duty: _____, 20____
15. Will Employee require further medical treatment? Yes No If yes, date of next appointment _____, 20____
16. Comments: _____

17. SIGNATURE OF PHYSICIAN; including degrees or credentials:
(I certify that the statements apply to this bill and are made a part thereof.)
SIGNED _____ DATE _____

18. PHYSICIAN'S ADDRESS, ZIP CODE & PHONE:
PIN# _____ GRP# _____

MEDICAL RECORDS RELEASE AUTHORIZATION

THIS REPORT IS TO BE COMPLETED IN ITS ENTIRETY BY THE EMPLOYEE
Fax or Email this completed form to GREAT AMERICAN INSURANCE COMPANY (972) 930-9479 or EMAIL:
txnonsubscriberclaims@gaic.com

EMPLOYER INFORMATION: _____
ADDRESS: _____ City: _____ State TX Zip: _____
PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

I hereby authorize _____ [name of physician, hospital or health care provider] to furnish to GREAT AMERICAN INSURANCE COMPANY, its employees, agents, and authorized representatives (hereafter individually and collectively referred to as "GAIC"), any and all of my medical records and related information pertaining to my care and treatment as the result of my injury, illness, and/or claim for benefits. The medical records and related information includes, but is not limited to, medical histories, reports, charts, notes, letters, x-rays, films, MRIs, CT scans and reports, itemized bills with treatment codes, insurance and claim records, correspondence, payments, consultations, examinations, prescriptions, diagnoses, tests, and treatments.

I understand that this information is being obtained to assist in the evaluation of my claim for benefits.
I understand that this information may be used to adjust, describe, or report matters about my care and treatment to persons entitled to receive this information.

I understand that I may revoke this authorization at any time by sending written notice to GAIC except to the extent that GAIC and _____ [name of physician, hospital or health care provider] have taken action in reliance on this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to further disclosure and no longer protected by the federal health information privacy regulations. However, GAIC will take precautions to maintain the confidentiality of the information disclosed pursuant to this authorization. I hereby release GAIC from any liability or loss due to the release of any such information.

Nothing contained herein shall affect the treatment, payment, enrollment, or eligibility for benefits in accordance with all applicable laws.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction. A photocopy of this authorization shall have the same validity as the original.

Signed _____ Date _____
Name _____ SSN# _____
Address _____ Telephone (_____) _____

Representative (if applicable) _____ Relationship or Authority of Representative _____

Decline Medical Treatment Form

Fax or Email this completed form to GREAT AMERICAN INSURANCE COMPANY (972) 930-9479 or EMAIL: txnonsubscriberclaims@gaic.com

EMPLOYER INFORMATION: _____
ADDRESS: _____ City: _____ State <u>TX</u> Zip: _____
PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

I _____ choose to decline medical treatment that has been offered to me for an injury that was sustained on _____. I am aware that by declining medical treatment at this time, that my employer, _____ will not be responsible for any medical expenses or lost wages unless specifically approved by _____.

Employer

Employee

Employer Representative

Date