EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:
Your employer is insured by:

Insurer

Street and Number

City | State | Zip Code

For the period from _____ Through _____

Adjusting Company

Street and Number

City | State | Zip Code | Telephone

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act

Employer

By

Title

Witness

Witness

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the “Report of Occupational Injury or Illness” form from your employer for this purpose

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Suite 304
Anchorage AK 99503
(907) 269-4980

FAIRBANKS
675 7th Ave
Station K
Fairbanks AK 99701-4531
(907) 451-2889

JUNEAU
PO Box 115512
1111 W 8th St Rm 305
Juneau AK 99811-5512
(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

ALASKA DEPARTMENT OF LABOR &
WORKFORCE DEVELOPMENT
Division of Workers' Compensation
P.O. Box 115512, Juneau, AK 99811-5512
Fax: (907) 465-2797
workerscomp@alaska.gov

CLAIM FOR WORKERS' COMPENSATION BENEFITS

AWCB Case Number:

This Claim form is used to request benefits an employer has not paid and to which you believe you are entitled. It should be filed only after the employer has reported the employee's injury to the Division by filing a Report of Injury form. If the employer refuses to file or is unavailable to complete a Report of Injury form, please contact the Division.

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
4. Address (No., Street, City, State & Zip Code)	5. City/Town/Village Where Injury Occurred	6. Social Security No.
7. E-Mail Address (if available) Telephone	8. Occupation	9. Date of Birth

10. Name and Office of Employee's Attorney (if no attorney, leave blank)	11. Attorney's Telephone No.
12. Attorney's Address (No., Street, City, State & Zip Code)	13. Attorney's E-mail Address (Required)

14. Employer at Time of Injury	15. Insurer/Adjusting Company
16. Address (No., Street, City, State & Zip Code)	17. Address (No., Street, City, State & Zip Code)

18. Claim against the Benefits Guaranty Fund (Fund). If you suspect the employer (box 14) was uninsured for workers' compensation liability on the date of injury and failed to pay its employee (box 1) benefits due under the Alaska Workers' Compensation Act, you may be able to file a claim against the Fund. The Division will verify and confirm employer's workers' compensation coverage. Are you also filing against the Fund? ☐ YES ☐ NO

19. Describe the nature of the injury or illness, how the injury or illness happened, and part of body injured. Attach additional pages if necessary:

_____

_____

_____

_____

20. Reason for filing claim (be specific.) Attach additional pages if necessary: _____

_____

_____

_____

21. CLAIM IS MADE FOR:

a. ☐ Temporary Total Disability	f. ☐ Unfair or Frivolous Controversion (Denial)	j. ☐ Penalty for Late Paid Compensation
b. ☐ Temporary Partial Disability	g. ☐ Attorney's Fees and Costs	k. ☐ Interest
c. ☐ Permanent Total Disability	h. ☐ Transportation Costs	l. ☐ Death Benefits – Attach list of beneficiaries, including name, age, relationship and address.
d. ☐ Permanent Partial Impairment	i. ☐ Medical Costs State amount requested. $	
e. ☐ Compensation Rate Adjustment - Attach earnings records. See brochure Workers' Compensation & You for more information.		m. ☐ Other – In #20 above, provide details and amount.

22. Claimant's Name (if other than employee)	23. Telephone
24. Claimant's Address City State Zip Code	

FORM WILL BE RETURNED UNLESS SIGNED BELOW

25. Name of Individual Submitting the Form (print or type)	26. Signature	27. Date
28. Address City State Zip Code		29. Telephone

FILE WITH ALASKA WORKERS' COMPENSATION BOARD

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
P.O. Box 115512, Juneau AK 99811-5512

EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

EMPLOYEE: All questions with an asterisk (*) must be completed

1. Employee Name Last* | **First*** | **Middle** | **Suffix**

2. Mailing Address & Telephone Number*

City* | **State*** | **Zip Code***

Country, if outside the United States | **Telephone No.**

3. Date of Birth*

4. Date of Death

5. Social Security Number*

6. Gender Code ☐ F ☐ M ☐ U

7. Marital Status ☐ M-Married ☐ S-Separated ☐ U-Unmarried ☐ K-Unknown

8. Number of Dependents

9. Date of Injury / Illness*

10. Time of Injury / Illness

11. Did Injury / Illness Occur on Employer's Premises? ☐ Y-Yes ☐ N-No

12. Explain where injury / illness occurred

13. Employer Name*

14. Describe Nature of Injury / Illness* (i.e., sprain, laceration, etc.)

15. Describe Part of Body Affected*

16. Describe How the Injury / Illness Happened

17. Injury / Illness Due to Machine/Product Failure? DROP DOWN

18. Mechanical Guard/Safeguards Provided? DROP DOWN

19. List Any Machine/Substance/Object Causing Injury / Illness

20. If Machine What Part?

21. Witness Name | **Witness Business Phone Number**

22. Attending Physician Name & Contact Information

23. Hospital Name & Contact Information

24. Initial Treatment*

☐ 0-No Medical Treatment
☐ 1-Minor On-site Remedies by Employer Medical Staff
☐ 2-Minor Clinic/Hospital Remedies and Diagnostic Testing
☐ 3-Emergency Evaluation, Diagnostic Testing, and Medical Procedures
☐ 4-Hospitalization Greater than 24 Hours
☐ 5-Future Major Medical/Lost Time Anticipated

25. Employee Authorization to Release Medical Records*

To all health care providers:

You are authorized to provide my employer (named in box 13), its workers' compensation liability insurance company, and its claims adjuster information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 16. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This authorization is valid for a one-year period from the date of my signature (box 23). I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

Employee Signature:

26. If Employee Unavailable for Signature, Explain Circumstances in this Space

27. Date Signed

WARNING TO EMPLOYEES AND EMPLOYERS: AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or employee misclassifications.

ORIGINAL TO EMPLOYER IMMEDIATELY **COPY TO EMPLOYEE**

EMPLOYER: File the complete First Report of Injury (FROI), form 07-6101, with the Alaska Division of Workers' Compensation by electronic data interchange (EDI), or by mail, within 10 days of receiving this report, per AS 23.30.070(a).

Instructions for
EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

TO THE EMPLOYEE

You must complete and sign this form. Keep a copy of the completed form for your records, and immediately give this form to your employer. You should notify your employer immediately, but no later than 30 days after your injury occurred or illness began.

The employer will notify their insurer, their claims administrator, and the Division of Workers' Compensation of your injury.

After obtaining medical treatment, tell your health care provider's office to submit the required "Physician's Report" (8 AAC 45.086) to your employer.

You will not be paid compensation for lost wages for the first three (3) days off work unless your disability lasts more than 28 days. The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury, illness or disease. After the first payment, you should get a check every two (2) weeks while you are disabled. If you have not received payment within 21 days from the date you were injured or became ill, contact the insurer or adjuster first. If you have any questions or problems, contact the Division of Workers' Compensation office nearest you (contact information listed below). If you are off work for three (3) or more days, you will need to provide additional information to your employer's claims adjuster regarding your wages, marital status, and number of dependents.

If you believe your work-related injury or illness will keep you from returning to your job at the time of injury, you may need retraining. The training benefits to which you may be entitled, and how you go about getting them, depend on your date of injury. If you are off work for 45 days, contact the division office in Anchorage to learn more about your rights for reemployment benefits. You may also refer to the Reemployment Benefits section of the "Workers' Compensation and You" brochure available at the Division's internet web page:

www.labor.state.ak.us/wc

INFORMATION IN FILES MAINTAINED BY THE DIVISION OF WORKERS' COMPENSATION, EXCEPT FOR MEDICAL AND REHABILITATION RECORDS, IS AVAILABLE FOR PUBLIC REVIEW AND COPYING FOR NONCOMMERCIAL PURPOSES.
AS 23.30.107

TO THE EMPLOYER

The information on this form (07-6100) and the information on form 07-6101 must be submitted to the Division of Workers' Compensation immediately and in no case later than **ten (10) days** after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you.

Failure to file these reports within the required time may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker.

Alaska Division of Worker's Compensation Offices

Anchorage:
3301 Eagle Street, Suite 304
Anchorage, AK 99503-4149
(907) 269-4980

Fairbanks:
675 Seventh Avenue, Station K
Fairbanks, AK 99701-4531
(907) 451-2889

Juneau:
1111 W 8th St, Rm 305, Juneau AK 99801
PO Box 115512, Juneau AK 99811-5512
(907) 465-2790

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Division of Workers' Compensation
P.O. Box 115512, Juneau AK 99811-5512

EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO DIVISION OF WORKERS' COMPENSATION

EMPLOYER: All questions with an asterisk (*) must be completed

1. Employer Name*
2. Industry (NAICS) Code Required on New Claims* See http://www.census.gov/cgi-bin/sssd/naics/naicsrch
3. Employer Contact Name & Telephone
4. FEIN*
5. UI Number
6. Employer Mailing Address*
   City State Zip Code
   Country, if outside the United States
7. Employer Physical Address
   City State Zip Code
   Country, if outside the United States
8. Employee Name, Last First Middle Suffix
9. Employee Mailing Address*
   City State Zip Code
10. Date of Birth*
11. Date of Death
12. Employee ID Type & Number*
    Country, if outside the United States

Blocks 13– 20 are to be completed by the Insurer /Claims Administrator submitting this report to the Division of Workers' Compensation

13. MTC Report*
14. JCN /AWCB*
15. Claim Status*
16. Claim Type*
17. Late Reason Code
18. Full Denial Reason Code
19. Full Denial Effective Date
20. Denial Reason Narrative
21. Policy Information Number Effective Date Expiration Date
22. Insurer Name
23. Insurer FEIN
24. Insurer Type Code*
25. Claim Administrator Name*
26. Claim Administrator Primary Address*
    City State Zip Code
27. Claim Admin FEIN*
28. Claim Admin Claim No.*
29. Claim Admin Physical/Alternate Postal Code*
30. Insured Name
31. Insured FEIN
32. Insured Type Code*
33. Employment Status*
34. Days Worked /Week
35. Wage
36. Wage Period Code
37. Employee Hire Date
38. Occupation /Job Title
39. Full Wages Paid for Date of Injury Indicator
40. Employer Paid Salary in Lieu of Compensation Indicator

Employer must complete either Block 41 or 42 AND Block 43

41. Accident Site Information, if not on Employer Premises
    Organization Name
    Street
    City State Zip Code
    Country, if outside the United States
42. Explain Where Injury Occurred
43. Accident Premises Code*
44. Date of Injury /Illness*
45. Time of Injury /Illness
46. Date Employer First Knew of Injury /Illness
47. Date Claim Admin Knew of Injury /Illness

For Blocks 48, 49 & 50 see: https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx

48. Part(s) of Body Affected*
49. Nature of Injury /Illness*
50. Cause of Injury /Illness*
51. Death Result of Injury Code
52. Initial Last Day Worked
53. Initial Date Disability Began
54. Initial Return to Work Date
55. Return to Work Type Code*
56. Return to Work With Same Employer?
57. Physical Restrictions Indicator
58. Signature of Authorized Employer or Representative
59. Title
60. Date Signed

Instructions for

EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO ALASKA DIVISION OF WORKERS' COMPENSATION

Employer: This form must be completed and sent immediately, and in no case later than **ten (10) days** after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you. You have the option of completing this form electronically or by hand prior to sending the completed to your Insurer/Claims Administrator (Adjuster).

The form should be submitted electronically via electronic data interchange (EDI). If you or your insurer is not registered and approved to submit reports electronically, mail this form (07-6101) and form 07-6100 to the Division of Workers' Compensation, P.O. Box 115512, Juneau, AK 99811-5512. Make sure and keep a copy for your records.

Failure to file this report within the required time may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker.
AS 23.30.070

INFORMATION IN FILES MAINTAINED BY THE DIVISION OF WORKERS' COMPENSATION, EXCEPT FOR MEDICAL AND REHABILITATION RECORDS, IS AVAILABLE FOR PUBLIC REVIEW AND COPYING FOR NONCOMMERCIAL PURPOSES.
AS 23.30.107

OSHA REQUIREMENTS

Report industrial deaths and accidents to the Division of Labor Standards and Safety.

Alaska Statute 18.60.058 requires employers to report to Division of Labor Standards and Safety any employment accident which is fatal to one or more employees or which results in the overnight hospitalization of one or more employees. The report, which must be made immediately, but no later than 8 hours after receipt by the employer of information that the accident has occurred, must relate the circumstances of the accident, the number of fatalities, and the extent of the injuries.

Monday-Friday Alaska OSH (800) 770-4940 · 24-hour OSHA Hotline (800) 321-6742

"Injury" means accidental injury or death arising out of in the course of employment and an occupational disease, illness, or infection which arises naturally out of the employment or which naturally or unavoidably results from an accidental injury.

"Injury" does not include mental injury caused by stress unless it is established that (A) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, and (B) the work stress was the predominant cause of the mental injury. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

	Alaska Division of Worker's Compensation Offices:	**Alaska Division of Labor Standards and Safety Offices:**
Anchorage:	3301 Eagle Street, #304 Anchorage, AK 99503-4149 (907) 269-4980	3301 Eagle Street, #305 Anchorage, AK 99503-4149 (907) 269-4940 or (800) 770-4940
Fairbanks:	675 Seventh Avenue, Station K Fairbanks, AK 99701-4531 (907) 451-2889	
Juneau:	1111 West 8th Street, #305 PO Box 115512 Juneau, AK 99811-5512 (907) 465-2790	1111 West 8th Street, #304 PO Box 111149 Juneau, AK 99811-1149 (907) 465-4855

PHYSICIAN'S REPORT

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

◯ **INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
◯ **PROGRESS** Physician: Sections 1 & 4
◯ **TREATMENT PLAN** Employee: Sections 1 & 2/ Physician: Sections 3 & 4

AWCB Case Number:

SECTION 1

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number	3. Date of Injury
4. Address				5. Sex ◯ Male ◯ Female	6. Social Security Number
City	State	Zip Code	Telephone		7. Date of Birth
8. Employer				9. Insurer	
10. Address				11. Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

SECTION 2

12. Date Last Worked

13. Was Body Part Injured Before? ◯ No ◯ Yes
If yes, when and describe:

14. Describe Injury and Tell How It Happened:

15. Have You Seen Any Other Doctor for This Injury? ◯ No ◯ Yes
If yes, list name and address:

16. Hospitalized As Inpatient? ◯ No ◯ Yes
Name of Hospital:

SECTION 3

17. Your First Treatment Date

18. Describe Complaints:

19. Fully Describe Findings on First Examination (Specify Right or Left):

20. Diagnosis:

21. X-Rays? ◯ No ◯ Yes X-Ray Diagnosis:

22. Is Condition Work Related? ◯ No ◯ Yes Explain:
◯ Undetermined (Explain):

SECTION 4

23. Treatment Date(s) Since Last Report

24. Next Treatment Date

25. Estimate Length of Further Treatment
Days Weeks Months

26. Medically Stable? ◯ No ◯ Yes

27. Date of Medical Stability

28. Injury May Permanently Preclude Return to Job at Time of Injury ◯ No ◯ Yes ◯ Undetermined

29. Will Injury Result in Permanent Impairment? ◯ No ◯ Yes ◯ Undetermined

30. Impairment Rating

31. Factors on Which Rating is Based

32. Released for Work ◯ No ◯ Yes ◯ Regular Work (Date): ◯ Modified Work (Date): Give Limitations:
Estimate Length of Disability ◯ 1-3 Days ◯ 4-7 Days ◯ 8-14 Days ◯ 15-21 Days ◯ 22-28 Days ◯ More _____Weeks _____Months

33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.

34. Describe Treatment (and/or Attach Notes)

35. If Case Referred to Another Physician, State Name and Address:

36. IRS I.D. Number

37. Physician's Name and Degree (Print or Type)

38. Physician's Signature

39. Report Date

40. Address City State Zip Code

41. Telephone

SEE INSTRUCTIONS ON BACK

INSTRUCTIONS TO PHYSICIANS:

1. Clearly mark on reverse whether you are making an Initial, Treatment Plan, or Progress Report.
2. When making an Initial Report or Treatment Plan Report, ask employee to complete Sections 1 and 2. You should complete Sections 3 and 4.
3. When making a Progress Report, complete Items 1, 3, 6, 7, 8 and 9 of Section 1 (you may complete additional items for your own convenience) and Section 4.
4. A Treatment Plan IS REQUIRED ONLY if you treat the injured worker MORE OFTEN than provided in the following chart:

1st MONTH	2nd & 3rd MONTHS	4th & 5th MONTHS	6th THRU 12th MONTH
3 treatments per week	2 treatments per week	1 treatment per week	1 treatment per month

5. Within 14 days after each treatment, send the ORIGINAL report to the Employer. If you treat the employee more frequently than once every 14 days, you may report all treatments during a 14-day period on one form.
6. Send your billing only to the employer/insurer; the Board does not pay medical expenses.
7. If you need more space than that provided on the front of the form, use the space below.
8. You may make copies of this form.
9. Late or incomplete reporting may delay the employee's compensation payments. The employer/insurer may not be required to pay your treatment if reports are not submitted timely.

INSTRUCTIONS TO EMPLOYEE:

1. Complete Sections 1 and 2 of the Initial Report.
2. The report is NOT a substitute for your written notice of injury to your employer and the Alaska Workers' Compensation Board. If you have not already done so, immediately contact your employer and complete Items 1 through 17 of the Report of Occupational Injury or Illness (Form 07-6101).

42. Employee's Name (Last, First, Middle Initial)	43. Report Date
44. REMARKS (or Treatment Plan continued)	

Medical records in an employee's file maintained by the board are not public records subject to public inspection and copying under AS 09.25.

RELEASE OF MEDICAL INFORMATION

RE: _____ v. _____

Alaska Workers' Compensation Claim No.: _____

TO: Any doctor, chiropractor, hospital, clinic, health insurer, physical therapist, government agency, insurer, employer or other person, entity, firm, or organization having custody of medical records or medical information pertaining to me, the undersigned person

I, the undersigned person, give my consent and authorize you to release the following medical records and information in your possession to _____, the defendants, or representative of the defendants, in the above Workers' Compensation Claim filed by me. I also consent and authorize, but do not necessarily request, you to discuss the following medical records and information pertaining to me with the defendant or the defendant's representative.

Medical records and information relating to the treatment of my injury or illness at work, and the following parts of my body, diagnoses or conditions, organ systems, chief complaints and/or symptoms:

_____

_____.

This authorization releases medical information from _____ (two years before the date of my earliest work injury or illness related to my claim) to the present.

You should interpret the terms “medical information” and “medical records” broadly to include records, reports, notes, chart notes, letters, photographs, test reports or results (including, as applicable, physical test results, pathology test results, laboratory test results, x-rays, MRI & CAT scans, EMGs, EKGs, sonograms, etc.), bills, and referral letters in your possession, whether generated by you or received from a third party.

This release of information is intended to include records maintained in my maiden or other names as follows: _____.

Please consider a photostatic copy of this authorization to release records to be as effective and valid as the original signed by me.

This release, and all authority to disclose information pertaining to me, shall expire on: _____ (one year from the date of the signature below), unless earlier revoked by me in writing.

Signature: _____ Dated this _____ day of _____ , _____

Printed Name: _____

Under AS 23.30.107, an employee must provide written release of medical and rehabilitation information relating to the injury. Parties should informally resolve disputes over what is relevant. Only if informal resolution is impossible, an employee may petition for a prehearing and a protective order within 14 days after receipt of the request to sign the release. AS 23.30.108.

TO HEALTH CARE PROVIDERS: 45 C.F.R. 164.512(l) exempts workers' compensation disclosures from HIPAA.