

EMPLOYERS' NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by

Insurer (Or Insurance Company)

Street and Number

City State Zip Code

For the period from _____ through _____

Alaska 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 Board 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 Board at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Box 107019
Anchorage, AK 99510-7019
(907) 269-4980

FAIRBANKS
675 Seventh Avenue
Station H2
Fairbanks, AK 99701-4593
(907) 451-2889

JUNEAU
1111 West 8th Street
Box 25512
Juneau, AK 99802-5512
(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.