

# 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 7<sup>th</sup> Ave  
Station K  
Fairbanks AK 99701-4531  
(907) 451-2889

JUNEAU  
PO Box 115512  
1111 W 8<sup>th</sup> 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.