# 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
PO Box 107019

3301 Eagle St Ste 304
Anchorage AK 99510-7019
(907) 269-4980

FAIRBANKS
675 Seventh Ave

Station K
Fairbanks AK 99701-4586
(907) 451-2889

JUNEAU
PO Box 115512

1111 W 8th St Room 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.