AmTrust North America
An AmTrust Financial Company

Alaska
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

Table of Contents

AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?

- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.

We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.

Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

MKT6310 06/23

AmTrust North America
An AmTrust Financial Company

EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
An AmTrust Financial Company

Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

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*
P.O. BOX 89404
CLEVELAND OH 44101-6404

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	1251 Muldoon Road, Suite 109 Anchorage, AK 99504 (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

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

AmTrust North America
Insurer

PO Box 89404
Street and Number

Cleveland | OH | 44101
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

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?

18. Mechanical Guard/Safeguards Provided?

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

WORKERS' COMPENSATION MEDICAL SUMMARY

This form must accompany Workers' Compensation Claims and Petitions (See 8AAC 45.052).

1. A copy of the Summary (and any attachments) MUST be served on the adjuster or attorney of record.
2. Send the original of the Summary and copies of the attachments to the Alaska Workers' Compensation Board (addresses listed below).

Employee's Name (Last, First, Middle Initial)	AWCB Case Number	Date of Injury
Employer	Employee's Social Security Number	

TO: (List all persons to whom you are mailing this summary. Include addresses.)

☐ Please mark an "X" here if you have no NEW medical records in your possession of this date.

List Medical Records in Chronological Order			Brief Description of Medical Record (option but please identify most important records).
1. Report Date	Doctor/Provider	Report Type	
2. Report Date	Doctor/Provider	Report Type	
3. Report Date	Doctor/Provider	Report Type	
4. Report Date	Doctor/Provider	Report Type	
5. Report Date	Doctor/Provider	Report Type	
6. Report Date	Doctor/Provider	Report Type	
7. Report Date	Doctor/Provider	Report Type	
8. Report Date	Doctor/Provider	Report Type	
9. Report Date	Doctor/Provider	Report Type	
10. Report Date	Doctor/Provider	Report Type	
11. Report Date	Doctor/Provider	Report Type	
12. Report Date	Doctor/Provider	Report Type	
13. Report Date	Doctor/Provider	Report Type	
14. Report Date	Doctor/Provider	Report Type	
15. Report Date	Doctor/Provider	Report Type	

Proof of Service: I certify that I mailed a copy of this summary to the persons and addresses listed above:

Name of Person Who Prepared This Summary (Print or Type)

Name of Person Certifying Service (Print or Type)

Signature

Date Mailed

REPORT TYPE CODE: Chart Notes =C, Discharge Summary = D, Hospital Records =H, Initial Report = I, Narrative Report =N, Operative Report = O, Physical Examination & History = E, Progress Report = P, X-Ray Report = X, Miscellaneous = M, Second Independent Medical Evaluation = SIME, Employer Independent Medical Evaluation = EIME

Alaska Department of Labor & Workforce Development
Alaska Workers' Compensation Board
P.O. Box 115512
Juneau, AK 99811-5512
(907) 465-2790

Alaska Department of Labor & Workforce Development
Alaska Workers' Compensation Board
3301 Eagle Street, Suite 304
Anchorage, AK 99503
(907) 269-4980

Alaska Department of Labor & Workforce Development
Alaska Workers' Compensation Board
675 Seventh Avenue, Station K
Fairbanks, AK 99701-4531
(907) 451-2889

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

Petition

(Do Not Use As A Claim For Benefits)

AWCB Case Number:

To the Person Receiving this Petition: You have 20 days after the date this petition was served on you to respond in writing. Your response to this petition must be filed with the Alaska Workers' Compensation Board (AWCB), and it must show that a copy was given to the person who submitted this petition (see #22 below). If you have an attorney and you have questions, contact your attorney. If you do not have an attorney and you have questions, contact the AWCB.

1. Employee's Name (Last, First, Middle Initial)			2. Insurer Claim Number	3. Date of Birth	4. Date of Injury
5. Address	City	State Zip Code		E-mail Address	Telephone
6. Employer			7. Insurer/Adjusting Company		
8. Address	City	State Zip Code	9. Address	City	State Zip Code
E-mail Address	Telephone	Fax Number	E-mail address	Telephone	Fax Number

PETITION TYPE – CHECK APPROPRIATE BOXES.

10. ☐ PROTECTIVE ORDER
11. ☐ COMPEL DISCOVERY
12. ☐ CONTINUE OR CANCEL HEARING
13. ☐ SIME - EXAMINATION BY BOARD-SELECTED PHYSICIAN UNDER AS 23.30.095(k)
14. ☐ REVIEW OF REEMPLOYMENT BENEFIT ADMINISTRATOR'S DECISION UNDER AS 23.30.041 AND REQUEST FOR HEARING UNDER AS 23.30.110
15. ☐ RECONSIDERATION
16. ☐ JOIN ADDITIONAL EMPLOYER(S) AND/OR INSURER(S): Pursuant to 8 AAC 45.040(g).
17. ☐ MODIFICATION AS 23.30.130
18. ☐ REQUEST FOR EXTENSION OF TIME TO REQUEST A HEARING UNDER AS 23.30.110(c)
19. ☐ OTHER: _____

REASON FOR PETITION – STATE IN DETAIL. ATTACH ADDITIONAL PAGES IF NECESSARY.

_____

_____

20. ☐ COMPLETE MEDICAL SUMMARY (Form 07-6103) AND ATTACH IF REQUIRED UNDER 8 AAC 45.052.

21. PROOF OF SERVICE: I certify that on the date in #23 below, I provided a true and correct copy of this petition on the following (your petition will be returned if you do not show service to all parties and employers/insurers sought to be joined):

a.	The EMPLOYEE in #1 to the address/e-mail in #5 by:	☐ Mail	☐ E-mail	
b.	The EMPLOYER in #6 to the address/e-mail/fax in #8 by:	☐ Mail	☐ E-mail	☐ Facsimile
c.	The INSURER in #7 to the address/e-mail/fax #9 by:	☐ Mail	☐ E-mail	☐ Facsimile
d.	OTHER (state name and address, e-mail or fax) by:	☐ Mail	☐ E-mail	☐ Facsimile

FORM WILL BE RETURNED UNLESS SIGNED BELOW

22. Name of Individual Filing this Form (Print or Type)	23. Signature	24. Date
25. Address	City State	Zip Code

FILE WITH ALASKA WORKERS' COMPENSATION BOARD

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: _____ Employer: _____ Claim Number: _____
Social Security Number: _____ Date of Hire: _____ Position/Job Title: _____

EMPLOYMENT TYPE: Full Time____Part Time____Seasonal____Temp_____
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly____Salary____Commission____
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ____Yes ___No
Hours per Week _____ ; Overtime Rate $_____per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____per week Auto: $_____ Rent/Lodging: $_____per week Bonus $_____ per ☐wk ☐mth ☐yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					