# 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 | FAIRBANKS | JUNEAU |
|---|---|---|
| 3301 Eagle Street | 675 7th Avenue | PO Box 115512 |
| Suite 304 | Station K | 1111 W 8th St Room 305 |
| Anchorage, AK 99503 | Fairbanks, AK 99701-4586 | Juneau, AK 99811-5512 |
| (907) 269-4980 | (907) 451-2889 | (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.

Form 07-6120 (Rev 05/2012)

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