EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

Berkley Industrial Comp
Insurer

P.O. Box 660847
Street and Number

Birmingham	AL	35266
City	State	Zip Code

For the period from _____ Through _____

Northern Adjusters, Inc.
Adjusting Company

1401 Rudakof Circle
Street and Number

Anchorage	AK	99508	(907) 868-3999
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 WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Report of Occupational Injury or Illness (Form 07-6101)

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Reports of Occupational Injury or Illness may be submitted to us online at: **https://berkindcomp.com**. Online Reporting Instructions are enclosed. Maintain a copy of the Report of Occupational Injury or Illness for your records. Keep a separate file for each workers' compensation claim.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the Report of Occupational Injury or Illness. If the Report of Occupational Injury or Illness is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Wage Statement

Wage statements must be completed on claims involving lost time from work. The employee's gross wages for the 52 weeks prior to the date of injury are required. If the employee has not been employed for 52 weeks, then report the available wages. In addition to regular pay, computation of wages may include overtime, tips, and the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

Please contact our claims department with questions.

Do not delay reporting the Report of Occupational Injury or Illness for completion of the wage statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

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*
    SELECT ONE
    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* SELECT ONE
14. JCN / AWCB*
15. Claim Status* SELECT ONE
16. Claim Type* SELECT ONE
17. Late Reason Code DROP DOWN LIST
18. Full Denial Reason Code
    DROP DOWN LIST
    DROP DOWN LIST
    DROP DOWN LIST
    DROP DOWN LIST
    DROP DOWN LIST
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* SELECT ONE
25. Claim Administrator Name*
26. Claim Administrator Primary Address*
    City State Zip Code
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* SELECT ONE
33. Employment Status* SELECT ONE
34. Days Worked / Week
35. Wage
36. Wage Period Code DROP DOWN LIST
37. Employee Hire Date
38. Occupation / Job Title
39. Full Wages Paid for Date of Injury Indicator DROP DOWN
40. Employer Paid Salary in Lieu of Compensation Indicator SELECT ONE

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* SELECT ONE
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 DROP DOWN LIST
52. Initial Last Day Worked
53. Initial Date Disability Began
54. Initial Return to Work Date
55. Return to Work Type Code* DROP DOWN LIST
56. Return to Work With Same Employer? DROP DOWN
57. Physical Restrictions Indicator DROP DOWN LIST
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

WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

"A" I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

"B" I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

	WEEK ENDING			Days Worked	Amount Paid Including Overtime		WEEK ENDING			Days Worked	Amount Paid Including Overtime
	Month	Day	Year				Month	Day	Year		
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					
			TOTAL PAID						TOTAL PAID		
									TOTAL GROSS		