

How to respond to a workplace injury:

For life-threatening medical emergencies, call **911**.

For non-life-threatening injuries, call the **24/7 Nurse Line at (844) 581-0828** to report the incident and get your employee the right care

Workers' comp claims

You can file your first report of injury for a workers' comp claim in three simple ways:

Call the 24/7 claim intake line within 24 hours of the incident: **(844) 581-0828**

Submit the claim information online here

Email the claims team within 24 hours of the incident: **claims@pieinsurance.com**

- **In your email, please include the following:**
- The name of your business
- The policy number
- Reporting party's contact information (name, phone, email)
- The name, phone, and email address of the injured employee
- Date of the injury or accident
- A description of the injury or accident

Thank you.



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 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.

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*				7. Employer Physical Address							
City		State		Zip Code		City		State		Zip Code	
Country, if outside the United States				Country, if outside the United States							
8. Employee Name, Last				First		Middle		Suffix			
9. Employee Mailing Address*				10. Date of Birth*			11. Date of Death				
City		State		Zip Code		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*							
27. Claim Admin FEIN*		28. Claim Admin Claim No.*		City		State		Zip Code			
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:				44. Date of Injury / Illness*			45. Time of Injury / Illness				
41. Accident Site Information, if not on Employer Premises Organization Name				46. Date Employer First Knew of Injury / Illness			47. Date Claim Admin Knew of Injury / Illness				
Street											
City		State		Zip Code		For Blocks 48, 49 & 50 see: https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx					
Country, if outside the United States				48. Part(s) of Body Affected*			49. Nature of Injury / Illness*				
42. Explain Where Injury Occurred				50. Cause of Injury / Illness*			51. Death Result of Injury Code DROP DOWN LIST				
43. Accident Premises Code* SELECT ONE		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