

WORKERS' COMPENSATION

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 _____

EMERGENCY INFORMATION

DOCTOR _____ **AMBULANCE** _____

HOSPITAL _____ **POLICE** _____

FIRE DEPT. _____ **OTHER** _____

ALL FATALITIES OR INJURIES RESULTING IN HOSPITALIZATION MUST BE REPORTED IMMEDIATELY (WITHIN 8 HOURS) TO THE
ALASKA DEPARTMENT OF
LABOR AND WORKFORCE DEVELOPMENT, DIVISION OF LABOR STANDARDS AND SAFETY AT:
1-800-770-4940 OR TO THE OSHA 24-HOUR HOT LINE AT **1-800-321-6742**
(AS 18.60.058(a))

Regular Paydays for Employees of

(Company Name)

Shall be as follows:

Weekly **Bi-Weekly** **Monthly** **Other** _____

By: _____ Title: _____

