Alaska National
INSURANCE COMPANY
SERVICE LEADER IN COMMERCIAL INSURANCE

IMPORTANT NOTICE

The State of Alaska no longer accepts claims through the mail/fax process. All claims must be reported directly to Alaska National Insurance Company who in turn will report the claim electronically.

Alaska National INSURANCE COMPANY
SERVICE LEADER IN COMMERCIAL INSURANCE

EMPLOYER/SUPERVISOR NOTICE OF OCCUPATIONAL INJURY OR ILLNESS FOR ALASKA WORKERS' COMPENSATION

○ **Report of Injury** ○ **Notification Only**

Section 1: Employer Information

Insured Name on Policy: _____

Location / Dept / Project: _____

Employer Contact Name: _____

Employer Phone Number: _____

Employer Physical Address
Street: _____

City: _____ State: _____ Zip: _____

Is this your mailing address? ☐ Yes If no, please provide the mailing address for claim communications.
Street: _____

City: _____ State: _____ Zip: _____

Section 2: Employee Information

Employee First Name: _____ ○ Male

Employee Last Name: _____ ○ Female

Employee Date of Birth: _____

Employee ID Number: _____

Type of ID provided: _____ (SSN, Passport, Visa or Green Card)

Employee Telephone Number: _____

Employee Mailing Address
Street: _____

City: _____ State: _____ Zip: _____

Section 3: Employment Information

Employee works (mark all that apply):

☐ Full Time ☐ Part Time ☐ Seasonal ☐ Other _____

☐ New Hire ☐ Re-Hire ☐ Union/Teamster ☐ Sub-Contractor ☐ Dept. Transfer

_____ hours per day _____ days per week is paid _____ per _____

Employee was hired on: _____

At time of hire, the employee was hired to work as: _____
Occupation/Job Title

On the date of injury, the employee began work at _____ and was performing the following tasks:

_____

Employee Name: _____

Section 4: Accident/Injury Information

On what date did the injury occur? _____
If no specific event, list the date the employee reported the injury or the date of medical treatment, whichever is first.

What time did the injury occur? _____

Did the employee report the injury? O Yes O No O Death Claim

If yes, to whom was the injury reported? _____

When was the injury reported? _____

How did the injury occur? Describe what happened including any equipment, object, or substance that harmed the employee.

_____

_____

What was the injury or illness? Tell us the part of the body affected and how it was affected.

_____

_____

When did the injury occur? Identify / describe the physical premises.

_____

_____

Construction Projects: specify if residential, commercial or industrial. Health Care Providers: specify facility type such as hospital, clinic, assisted living, etc. Trucking: specify type of freight and long vs short haul. Mining: specify type of material being mined.

What is the zip code where the injury occurred? _____

Is the property owned and/or maintained by the employer? O Yes O No

Was the employee paid their full wages for the date of injury? O Yes O No

Did the employee leave work early? O Yes O No

Has the employee returned to work? O Yes O No

If yes, what date did the employee return? _____

If yes, did the employee return to the same job / same schedule? O Yes O No

Did the employee receive medical care? O Yes O No

If yes, where was treatment received? Please provide name, address, and phone number of the medical provider:

_____

_____

_____

_____

If yes, did the employee provide a note excusing them from work? O Yes O No

Was the employee treated in an Emergency Room? O Yes O No

Was the employee hospitalized overnight as inpatient? O Yes O No

Signature of Authorized Employer Representative _____

Title _____

Date Signed _____

☐ Please contact me to discuss this claim. Phone Number: _____

Submit Notice to:
7001 Jewel Lake Road, Anchorage, AK 99502
claims tel (907) 266-9227 ● claims fax (907) 266-9250 ● claims e-mail anc_claims@alaskanational.com