ALASKA DEPARTMENT OF LABOR &
WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

WORKERS' COMPENSATION CLAIM

AWCB Case Number:

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number	3. Date of Injury
4. Address				5. City/Town/Village Where Injury Occurred	6. Social Security Number
City	State	Zip Code	Telephone	7. Occupation	8. Date of Birth
9. Employer at Time of Injury				10. Insurer/Adjusting Company	
11. Address				12. Insurer Address	
City	State	Zip Code	Telephone	City State Zip Code Telephone	

13. Describe how the injury or illness happened:

14. Part of Body Injured: ☐ Right ☐ Left

15. Nature of injury or illness:

16. Full name and address of attending physician(s):

17. Reason for filing claim (be specific):

18. This claim amends a prior claim dated:

CONTINUED ON BACK

WORKERS' COMPENSATION CLAIM (Continued from Front)

19. Employee Name	20. Date of Injury	21. AWCB Case Number

22. Employer	23. Insurer/Adjusting Company

24. CLAIM IS MADE FOR:

- ☐ a. Temporary Total Disability
  - From: _____ Through: _____
  - From: _____ Through: _____
  - From: _____ Through: _____
- ☐ b. Temporary Partial Disability
  - From: _____ Through: _____
- ☐ c. Permanent Total Disability
  - From: _____ Through: _____
- ☐ d. Permanent Partial Impairment
- ☐ e. Medical Costs (state amount requested)
  - $ _____
- ☐ f. Transportation Costs (state amount requested)
  - $ _____
- ☐ g. Review of Reemployment Benefit Decision
  - ☐ 1. Eligibility
  - ☐ 2. Plan Review
  - ☐ 3. Employee Cooperation
  - ☐ 4. Other (give details and amount requested in #17 above)
- ☐ h. Compensation Rate (Gross Weekly Earnings) Complete to #25 below
- ☐ i. Penalty (state amount requested)
  - $ _____
- ☐ j. Interest
  - $ _____
- ☐ k. Unfair or Frivolous Controvert (Denial)
- ☐ l. Attorney's Fees and Costs
  - $ _____
- ☐ m. Death Benefits
- ☐ n. Other (give details and amount requested in #17 above)

25. COMPLETE ONLY IF YOU CHECKED 24(h) ABOVE (Compensation Rate). ATTACH EARNING RECORDS AS INDICATED.
At the time of injury,

- ☐ a. Employee was a seasonal or temporary worker. (Attach copies of earnings documents for all work during the previous 12 months prior to the injury).
- ☐ b. Employee's earnings were calculated by the day, hour, or output. (Attach copies of documents showing wages from all occupations during either of the two calendar years immediately preceding the injury, whichever is most favorable to the employee.)
- ☐ c. Employee's earnings were calculated by the: ◯ Week ◯ Month ◯ Year (Attach copies of documents evidencing your rate of pay.)
- ☐ d. Employee's wages had not been set or cannot be determined. (Attach information about the usual wage for similar services.)
- ☐ e. Employee was employed by two or more employers. (Attach copies of earning records from all employers.)
- ☐ f. Employee was a minor, apprentice, or trainee in a formal training program.
- ☐ g. Employee was injured working as a volunteer ambulance attendant, volunteer medical technician, or volunteer fire fighter.
- ☐ h. Other _____

26. TO BE USED IN DEATH CASES ONLY. it is claimed the deceased left the following beneficiaries:

a. Name	b. Age	c. Relationship	d. Address

27. Applicant's Name (if other than employee)		28. Telephone
29. Applicant's Address	City	State Zip Code

FORM WILL BE RETURNED UNLESS SIGNED BELOW

30. Attorney's Name (if represented)		31. Telephone
32. Attorney's Address	City	State Zip Code

33. Name of Individual Submitting the Form (print or type)	34. Signature	35. Date
36. Address	City	State Zip Code

MAIL TO WORKERS' COMPENSATION DIVISION