PETITION TO JOIN SECOND INJURY FUND AND CLAIM FOR REIMBURSEMENT

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

(Type or Print)

(For AWCB Use Only)

This form should be filed only after the employer or the insurer has submitted a Notice of Possible Claim Against the Second Injury Fund (AWCB form 07-6110) and has paid at least 104 weeks in compensation payments. Since regulation 8 AAC 45.186(f) does not allow the Second Injury Fund to make lump-sum reimbursements, reimbursement for compensation between 104 weeks and the filing date of this petition will be made on a monthly basis. Second Injury Fund reimbursements are for disability payments only; attorney fees, medical payments and 041 (k) wages will not be reimbursed. Payment will be at the claimant's weekly compensation rate.

1. Employee's Name (Last, First, Middle Initial)	**2.** Insurer Claim Number / Date of Injury
3. Employee's Mailing Address	**4.** Employee's Social Security Number / Date of Birth
5. Employer's Name	**6.** Insurer's Name
7. Employer's Mailing Address	**8.** Insurer's Mailing Address

9. Provide date that a Notice of Possible Claim was filed. (AWCB form 07-6110)

10. State how the pre-existing condition, which combined with the occupational injury, creates a compensable condition greater than the occupational injury alone. (Attach supporting medical summaries.)

11. Report all compensation payments made to date or attach a current compensation report containing a history of payments.

Payment Date	Payment Type	From	Through	Weeks & Days	Weekly Rate	Total Amount
			Totals			

12. Name of Individual Submitting This Form	**13.** Signature of Individiual Submitting Form	**14.** Date
15. Mailing Address		**16.** Telephone Number