

CLAIM FOR WORKERS' COMPENSATION BENEFITS

AWCB Case Number:

This Claim form is used to request benefits an employer has not paid and to which you believe you are entitled. It should be filed only after the employer has reported the employee's injury to the Division by filing a Report of Injury form. If the employer refuses to file or is unavailable to complete a Report of Injury form, please contact the Division.

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
4. Address	City	State Zip Code
5. City/Town/Village Where Injury Occurred	6. Social Security No.	
7. E-Mail Address (if available)	Telephone	8. Occupation
		9. Date of Birth
10. Name and Office of Employee's Attorney (if no attorney, leave blank)	11. Employer at Time of Injury	
12. Attorney's Address (No., Street, City, State & Zip Code)	13. Employer Address (No., Street, City, State & Zip Code)	
14. Attorney's Telephone No.	15. Insurer/Adjusting Company	
16. Attorney's E-mail Address (Required)	17. Insurer/ Adjuster Address (No., Street, City, State & Zip Code)	
18. Claim against the Benefits Guaranty Fund. Applies <u>ONLY</u> if the employer was <u>NOT</u> insured for workers' compensation liability on the date of injury (the Division will verify employer's coverage.) If the employer (box 11) was uninsured for workers' compensation liability on the date of injury and failed to pay its employee (box 1) benefits due under the Alaska Workers' Compensation Act, are you also filing against the Fund? <input type="checkbox"/> YES <input type="checkbox"/> NO		
19. Describe the nature of the injury or illness, how the injury or illness happened, and part of body injured. Attach additional pages if necessary: _____ _____ _____		
20. Reason for filing claim (be specific): _____ _____ _____		
21. CLAIM IS MADE FOR:		
a. <input type="checkbox"/> Temporary Total Disability	f. <input type="checkbox"/> Unfair or Frivolous Controversion (Denial)	j. <input type="checkbox"/> Penalty for Late Paid Compensation
b. <input type="checkbox"/> Temporary Partial Disability	g. <input type="checkbox"/> Attorney's Fees and Costs	k. <input type="checkbox"/> Interest
c. <input type="checkbox"/> Permanent Total Disability	h. <input type="checkbox"/> Transportation Costs	l. <input type="checkbox"/> Death Benefits – Attach list of beneficiaries, including name, age, relationship and address.
d. <input type="checkbox"/> Permanent Partial Impairment	i. <input type="checkbox"/> Medical Costs (state amount requested) \$	
e. <input type="checkbox"/> Compensation Rate Adjustment - Attach earnings records. See brochure Workers' Compensation & You for more information.		m. <input type="checkbox"/> Other (Give details and amount requested in #20 above)
22. Claimant's Name (if other than employee)		23. Telephone
24. Claimant's Address	City	State Zip Code

FORM WILL BE RETURNED UNLESS SIGNED BELOW

25. Name of Individual Submitting the Form (print or type)	26. Signature	27. Date
28. Address	City	State Zip Code
		29. Telephone

FILE WITH ALASKA WORKERS' COMPENSATION BOARD