EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

Protective Insurance Company
Insurer

1099 N. Meridian St.
Street and Number

Indianapolis	IN	46204
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

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the “Report of Occupational Injury or Illness” form from your employer for this purpose.

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE	FAIRBANKS	JUNEAU
3301 Eagle Street	675 Seventh Avenue	PO Box 115512
Suite 304	Station K	1111 W 8th St Room 305
Anchorage AK 99503	Fairbanks AK 99701-4586	Juneau AK 99811-5512
(907) 269-4980	(907) 451-2889	(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.