ALASKA DEPARTMENT OF LABOR &
WORKFORCE DEVELOPMENT
Division of Workers' Compensation
P.O. Box 115512, Juneau, AK 99811-5512
Fax: (907) 465-2797
workerscomp@alaska.gov

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 (No., Street, 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. Attorney's Telephone No.
12. Attorney's Address (No., Street, City, State & Zip Code)	13. Attorney's E-mail Address (Required)

14. Employer at Time of Injury	15. Insurer/Adjusting Company
16. Address (No., Street, City, State & Zip Code)	17. Address (No., Street, City, State & Zip Code)

18. Claim against the Benefits Guaranty Fund (Fund). If you suspect the employer (box 14) 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, you may be able to file a claim against the Fund. The Division will verify and confirm employer's workers' compensation coverage. Are you also filing against the Fund? ☐ YES ☐ 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:

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20. Reason for filing claim (be specific.) Attach additional pages if necessary: _____

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21. CLAIM IS MADE FOR:

a. ☐ Temporary Total Disability	f. ☐ Unfair or Frivolous Controversion (Denial)	j. ☐ Penalty for Late Paid Compensation
b. ☐ Temporary Partial Disability	g. ☐ Attorney's Fees and Costs	k. ☐ Interest
c. ☐ Permanent Total Disability	h. ☐ Transportation Costs	l. ☐ Death Benefits – Attach list of beneficiaries, including name, age, relationship and address.
d. ☐ Permanent Partial Impairment	i. ☐ Medical Costs State amount requested. $	
e. ☐ Compensation Rate Adjustment - Attach earnings records. See brochure Workers' Compensation & You for more information.		m. ☐ Other – In #20 above, provide details and amount.

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