ARECA Insurance Exchange
703 West Tudor Road Suite 101
Anchorage, AK 99503-6650
P:(907)771-5750 F:(907)561-6206
Susan Kosinski, Claims Manager
skosinski@alaskapower.org

REPORT OF OCCUPATIONAL INJURY OR ILLNESS

EMPLOYEE SECTION ONLY: Answer ALL questions 1-24, sign, and give to your employer immediately.

1. Last Name, First Name, Middle Initial		2. Date of Birth	3. Sex ☐ M ☐ F / 4. Social Security No.
5. Mailing Address		6. Physical Address Same as Mailing Address ☐ Yes ☐ No	
5a. City, State, Zip Code		6a. City, State, Zip Code	
7. Home Phone Number	8. Cell Phone Number	9. Marital Status ☐ M-Married ☐ S-Single	10. No. of Children/Dependents
11. Date of Injury	12. Time of Injury ☐AM ☐PM	13. Premises ☐On Premises ☐Off Premises	14. If Not on Premises, Where Did Injury Happen? (Address, City, State, and Zip Code)
15. Cause of Injury (IE: Slip, Fall, Lifting, Pushing, etc.)		16. Nature of Injury (IE: Contusion, Sprain, Strain, etc.)	
17. Describe Body Part Affected ☐ Left ☐ Right		18. Witness Name	18a. Witness Phone Number

19. Describe How the Injury/ Illness Happened

20. Attending Physician Name & Contact Phone Number	21. Hospital Name & Contact Phone Number

22. Initial Treatment

- ☐ 0-No Medical Treatment
- ☐ 1-Minor On-site Remedies by Employer Medical Staff
- ☐ 2-Minor Clinic/Hospital Remedies & Diagnostic Testing
- ☐ 3-Emergency Evaluation, Diagnostic Testing, and Medical Procedures
- ☐ 4-Hospitalization Greater than 24 Hours
- ☐ 5-Future Major Medical/Lost Time Anticipated

23. To all health care providers:

You are authorized to provide my employer (named in Box 25) and ARECA Insurance Exchange information concerning any health care advise, testing, treatment, or supplies provided to me for the injury or illness described above in box 16. This information will be used to evaluate my entitlement to receive benefits, including payment of medical benefits, under the Alaska Workers' Compensation Act. This Authorization is valid for a one-year period from the date of my signature below. I know I have a right to receive a copy of this authorization and agree a photographic copy of this authorization is as valid as the original.

Employee Signature: Date Signed:

24. If Employee Unavailable for Signature, Explain Circumstances in this Space

EMPLOYER SECTION ONLY: Review Employee answers 1-24 and answer questions 25-46.

25. Employer Name		26. Contact Name	27. Contact Phone Number
28. Date Employer First Knew of Injury?	29. Date/Time Employee Left Work? ☐ AM ☐ PM	30. Off Work After Injury/Illness? ☐ Yes ☐ No ☐ 3 or More Days?	31. Return To Work Date?
32. Full Wages Paid for DOI? ☐ Yes ☐ No	33. Type of Employee? ☐ Regular/Full Time ☐ Part Time ☐ Seasonal ☐ Other	34. Employee's Occupation	

35. Give Details of How Injury or Illness Happened

36. Injury/Illness due to Machine/Product Failure? ☐ Yes ☐ No			37. Mechanical Guard/Safeguards Provided? ☐ Yes ☐ No	
38. Employee Hire Date	39. Wage $	40. Earnings Calculated by? ☐ Hr. ☐ Mo. ☐ Wk. ☐ Yr.	41. Days worked per week?	42. Scheduled Days off?
43. If Injury/Illness Caused by Anyone Besides Employee, Give Name & Contact Information				
44. Signature of Authorized Employer or Representative		45. Title	46. Date Signed	

WARNING TO EMPLOYEES AND EMPLOYERS: AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly making false statements, claims, or employee misclassifications.

DISTRIBUTION: Original -Employer; Copy –ARECA Insurance Exchange; Copy –Employee

Instructions for
REPORT OF OCCUPATIONAL INJURY OR ILLNESS FORM

TO THE EMPLOYEE

You must complete and sign this form. Keep a copy of the completed form for your records, and immediately give this form to your employer. You should notify your employer immediately, but no later than 30 days after your injury occurred or illness began.

The employer will notify ARECA Insurance Exchange and the Division of Workers' Compensation of your injury.

After obtaining medical treatment, tell your health care provider's office to submit the required "Physician's Report" (8 AAC 45.086) to ARECA Insurance Exchange. Please provide them with our contact information.

You will not be paid compensation for lost wages for the first three (3) days off work unless your disability lasts more than 28 days. The first installment of compensation becomes due on the 14th day after the employer has knowledge of the injury, illness or disease. After the first payment, you should get a check every two (2) weeks while you are disabled. If you have not received payment within 21 days from the date you were injured or became ill, contact ARECA Insurance Exchange first. If you have any questions or problems, contact the Division of Workers' Compensation office nearest you (contact information listed below). If you are off work for three (3) or more days, you may need to provide additional information to ARECA Insurance Exchange regarding your wages, marital status, and number of dependents.

If you believe your work-related injury or illness will keep you from returning to your job at the time of injury, you may need retraining. The training benefits to which you may be entitled, and how you go about getting them, depend on your date of injury. If you are off work for 45 days, contact the division office in Anchorage to learn more about your rights for reemployment benefits. You may also refer to the Reemployment Benefits section of the "Workers' Compensation and You" brochure available at the Division's internet web page:

www.labor.state.ak.us/wc

INFORMATION IN FILES MAINTAINED BY THE DIVISION OF WORKERS' COMPENSATION, EXCEPT FOR MEDICAL AND REHABILITATION RECORDS, IS AVAILABLE FOR PUBLIC REVIEW AND COPYING FOR NONCOMMERCIAL PURPOSES. AS 23.30.107

TO THE EMPLOYER

This form ARECA 6101 must be submitted to ARECA Insurance Exchange immediately and in no case later than ten (10) days after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you. An electronic copy must be emailed to Susan Kosinski, Claims Manager with a CC to Angie Moua, Claims Assistant. The original should be kept for your files and a copy for the employee.

Susan Kosinski, Claims Manager – skosinski@alaskapower.org

Angie Moua, Claims Assistant- amoua@alaskapower.org

Failure to file these reports within the required time may subject you and ARECA Insurance Exchange to a penalty equal to 20 percent of the amount of compensation due to the injured worker.

OSHA REQUIREMENTS

Report industrial deaths and accidents to the Division of Labor Standards and Safety. Alaska Statute 18.60.058 requires employers to report to Division of Labor Standards and Safety any employment accident which is fatal to one or more employees or which results in the overnight hospitalization of one or more employees. The report, which must be made immediately, but no later than 8 hours after receipt by the employer of information that the accident has occurred, must relate the circumstances of the accident, the number of fatalities, and the extent of the injuries.

Monday-Friday Alaska OSH (800) 770-4940 · 24-hour OSHA Hotline (800) 321-6742

> *"Injury"* means accidental injury or death arising out of in the course of employment and an occupational disease, illness, or infection which arises naturally out of the employment or which naturally or unavoidably results from an accidental injury.
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> *"Injury"* does not include mental injury caused by stress unless it is established that (A) the work stress was extraordinary and unusual in comparison to pressures and tensions experienced by individuals in a comparable work environment, and (B) the work stress was the predominant cause of the mental injury. A mental injury is not considered to arise out of and in the course of employment if it results from a disciplinary action, work evaluation, job transfer, layoff, demotion, termination, or similar action taken in good faith by the employer.

	Alaska Division of Worker's Compensation Offices:	Alaska Division of Labor Standards and Safety Offices:
Anchorage:	3301 Eagle Street, #304 Anchorage, AK 99503-4149 (907) 269-4980	3301 Eagle Street, #305 Anchorage, AK 99503-4149 (907) 269-4940 or (800) 770-4940
Fairbanks:	675 Seventh Avenue, Station K Fairbanks, AK 99701-4531 (907) 451-2889	
Juneau:	1111 West 8th Street, #305 PO Box 115512 Juneau, AK 99811-5512 (907) 465-2790	1111 West 8th Street, #304 PO Box 111149 Juneau, AK 99811-1149 (907) 465-4855