The Hanover Insurance Company | 440 Lincoln Street, Worcester, MA 01653
Citizens Insurance Company of America | 645 West Grand River Avenue, Howell, MI 48843

Report of Occupational Injury or Illness

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

AWCB Case Number (Division Use Only):

EMPLOYEE: Answer ALL questions 1-20, sign, and give to your employer immediately.

1. Last Name First Name Initial	2. Telephone Number	3. Date of Birth	4. Sex	5. Social Security No.

6. Mailing Address	7. Residence Address
6a. City State Zip Code	7a. City State Zip Code

8. Place (City/Town/Village/Camp) Where Injury/Occupational Illness Happened	9. Date of Injury or Exposure to Disease	10. On Employer's Premises?

11. Name and Address of Attending Physician	12. Hospitalization In-Patient?	13. Name of Hospital
City State Zip Code	City State Zip Code	

14. Describe Part(s) of Body Injured/Nature of Occupational Illness ☐ Left ☐ Right	15. Describe how the Injury or Occupational Illness happened

16. To all health care providers:
You are authorized to provide my employer (named in box 18), its workers' compensation liability insurance company (box 21), and its claims adjuster (box 22) information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 14. 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 (box 17a). 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/Patient's Signature:

17. If Employee Unavailable for Signature, Explain Circumstances in this Space	17a. Date Signed

EMPLOYER: Review employee answers 18-20, answer questions 21-49

18. Employer's Name	19. Employer's Alaska Address (If Different from Mailing)
20. Employer's Mailing Address (Street and Number)	21. Name of Insurer
20a. City State Zip Code 20b. Telephone	22. Full Name and Address of Adjusting Company
23. Date Employer First Knew of Injury / 24. Date/Time (AM/PM) Employee Left Work	22a. Mailing Address (Street and Number)
25. Off Work After Injury/Illness? ☐ Yes ☐ No / 26. Date Returned to Work / 27. Death? ☐ Yes ☐ No Date	22b. City State Zip Code / 22c. Telephone
28. Location Where Injury or Occupational Illness Happened	29. Employee's Occupation / 30. Date Hired by Employer
31. Earnings Calculated By ☐ Hr. ☐ Day ☐ Output ☐ Wk. ☐ Mo. ☐ Yr. / 32. Rate of Pay $ per / 33. Days Employee Works per Week ☐ 3 or Less ☐ 4 ☐ 5 ☐ 6 ☐ 7	34. Describe Scheduled Days Off
35. Workday Began ☐ AM ☐ PM / 36. Employee Paid for Day Injured or Ill? ☐ Yes ☐ No / 37. Federal EIN #	38. Give Details of How Injury or Illness Happened
39. Injury/Illness Due to Machine? Product Failure? ☐ Yes ☐ No / 40. Mechanical Guard/Safeguards Provided? ☐ Yes ☐ No	41. List Any Machine/Substance/Object Causing Injury / 42. If Machine, What Part
43. Name and Address of Witnesses	If Injury/Illness Caused by Anyone Besides Employee, Give Name and Address

46. If You Doubt Validity of Injury or Illness, State Reason

47. Signature of Authorized Employer or Representative	48. Title	49. Date Signed