WORKERS' COMPENSATION AND YOU

INFORMATION FOR INJURED WORKERS

This is basic information for injured workers. Read it carefully to know your rights and responsibilities. Workers' compensation laws require your employer to provide medical, disability and in some cases re-employment benefits if you are injured or become ill, if the injury or illness is caused by your work. Dependents may be eligible for death benefits. If you need additional information, please contact the Division of Workers' Compensation (Division) at (907) 465-2790 in Juneau, (907) 269-4980 in Anchorage or (907) 451-2889 in Fairbanks.

I. PROOF OF SERVICE

Many injured workers represent themselves in workers' compensation disputes. A **common mistake** injured workers make when representing themselves is failing to serve documents that they file with the Division, on the opposing party. If you want the Division or the Workers' Compensation Board (Board) to consider your arguments and evidence, **you must file it with the Division, with your name and case number included, and on the same date you must "serve" an exact copy of it on all parties to your case**. You must **certify in writing** the date you served all parties with the documents and how you served them (for example, by hand, mail, facsimile or email). If you are not sure upon whom to serve your documents, contact the nearest Division office for assistance. **The Division serves claims for benefits that you file, but you must serve petitions and any other documents you file, and provide proof of service on all parties**. **If you fail to follow these important steps, the Division and the Board may refuse to consider your arguments and evidence, which may result in lost benefits.**

II. CRITICAL TIME LIMITS

Another **common mistake** injured workers make when representing themselves is **failing to follow time deadlines** for filing documents and responding to the employer's or adjuster's filings.

When counting deadline days to file something, do not count the date of the triggering event. For example, if the adjuster **emails**, **faxes** or **hand-delivers** something to you on June 1, that is the triggering event that requires you to act. Start counting the days you have to respond on June 2.

Always count the last deadline day unless that day falls on a Saturday, Sunday or legal state holiday. If your filing deadline falls on a Saturday, Sunday or legal state holiday, move your deadline to the next day that is not a Saturday, Sunday or legal state holiday. For example, if the adjuster **emailed or faxed** you, or **hand-delivered** a document on June 1 and you had to object to it within 10 days, you would have to file and serve your objection by no later than June 11. If June 11 falls on a Saturday, Sunday or legal state holiday, your deadline date moves to the next day that is not a state holiday, a Saturday or a Sunday.

If your employer sends you a document by **US mail**, follow the above counting instructions to determine your deadline date, **then add three more days to your deadline date** because the employer served the document on you by mail. **Failure to file and serve documents timely may result in your evidence or arguments not being considered, and in lost benefits or even claim denial!**

Here are some key filing deadlines:

Reporting an Injury, Illness or Death: **Effective January 1, 2025**, you, or in the event of your death someone on your behalf, must report your work injury, illness or death to your supervisor **in writing no later than 15 days** from the event date; or 15 days from the date you later discover you have an injury, illness or death that you, or in death cases someone on your behalf, believe is work-related. If your injury occurred **before January 1, 2025**, your deadline to report your injury was **30 days**. **Filing an injury, illness or death report is not the same thing as filing a "claim."** Use Form 07-6100 from the Division's website at *labor.alaska.gov/wc* to report an injury, illness or death. **Failure to report your injury, illness or death timely may result in lost benefits or your right to any benefits may even be barred!**

Filing a Claim: If your employer sent you a Controversion Notice denying your right to benefits **before you filed a claim (a pre-claim controversion), you must file a claim for those denied benefits with the Division within two years from the date your employer filed the Controversion Notice**. If your employer **voluntarily paid and then terminated disability benefits without sending you a Controversion Notice, and you think you are entitled to more benefits, you must file a written claim for benefits with the Division within two years from the date your employer last paid you disability benefits**. **In death cases, dependents must file a claim within one year after your death**. Use Form 07-6106 from the Division's website to file a claim for benefits. The Division will file your claim. **Failure to file a claim for benefits timely may result in lost benefits or even claim denial!**

Requesting More Time to Request a Hearing: If your employer sends you a Controversion Notice **after you filed a claim (a post-claim controversion)**, **you must either request that a hearing be scheduled on your claim, or if you are not ready yet for a hearing** but your time is running out**,** you must file a Petition with the Division asking the Alaska Workers' Compensation Board (Board) to give you more time to get ready. **Your Petition requesting more time to prepare for a hearing must be filed within two years from the date your employer filed the post-claim Controversion Notice** with the Division. Use Form 07-6111 to request more time to prepare for a hearing. **Failure to request either a hearing, or more time to prepare for a hearing, timely may result in lost benefits**.

Filing a Claim Against an Uninsured Employer and the Workers' Compensation Benefits Guaranty Fund (the Fund): If your employer was uninsured on the date you were injured, you must also file a claim with the Division seeking benefits from the Fund. **Your claim against the Fund** may be made on the same Form 07-6106 you use to file against your uninsured employer **and must be filed with the Division within two years** of your injury or illness. The Division will serve your claim. **In death cases, dependents must file a claim against the uninsured employer and the Fund within one year after the death**. **Failure to file a claim for benefits against an uninsured employer and the Fund timely may result in lost benefits**.

Filing a Lien against an <u>Uninsured</u> Employer: If your employer was uninsured when you were injured, you have a right place a lien on your employer's business-related property. **A lien must be recorded in the Office of the Recorder of the Recording District in which the property affected by the lien is located, within one year after the date of your injury**. Use form 07-6179 to file your lien. You should also file with the Division and serve on the employer a copy of the lien. **Failure to file and record your lien timely with the Recorder's Office may result in you losing your ability to collect your workers' compensation benefits from your uninsured employer's business-related assets**.

Scheduling a Hearing: If you have everything you need for your hearing and are ready to schedule one, you must file with the Division an Affidavit of Readiness for Hearing (ARH) to get a hearing scheduled. **Your request to schedule a hearing must be filed and served within two years from the date your employer filed the post-claim Controversion Notice with the Division, unless you asked for and the Board granted more time for you to get ready for the hearing.** Use Form 07-6107 to schedule a hearing. **Failure to ask the Division to schedule a hearing timely may result in lost benefits.**

Opposing An Employer's Hearing Request: If your employer files an ARH and asks for a hearing on your claim before you are ready for a hearing, **you may object to a hearing being scheduled**. To object, you must file and serve an **affidavit of opposition within 10 days** after your employer filed its ARH. Your affidavit must state specific reasons why your case should not be scheduled for a hearing, why you are not ready, or why a hearing is not appropriate at that time. **Failure to timely file and serve an affidavit in opposition to an ARH may result in a hearing being scheduled before the Board before you are ready**. Use Form 07-**** to file an opposition to employer's hearing request.

Objecting to Medical and Other Releases: If your employer sends you releases to obtain your records, and you object to them, **you have 14 days, from the date the employer sent you the releases, to either sign, date and return unaltered releases, or file a petition with the Division objecting to the releases and requesting a protective order from the Board**. Use Form 07-6111 to file a petition. **Failure to sign, date and return to the employer unaltered releases, or to file and serve a petition requesting a protective order timely may result in benefit suspension or lost benefits**.

Complying with Board Designees' Orders: If a Board designee denies your request for a protective order and orders you in a prehearing conference or in a prehearing conference summary to sign and return releases, **you must do so within 10 days or your rights to benefits are suspended until you deliver the unaltered releases, and you may forfeit those benefits!**

Requesting a Second Independent Medical Evaluation (SIME): If your employer's physician disagrees with an opinion from your doctor, you **may** file a petition with the Division requesting an SIME with the Division's selected physician. You must **file and serve** your petition, related SIME Form, and the medical records showing the medical disputes **no later than 60 days from the date you obtained medical reports showing the medical disputes**. Use Forms 07-6111 and 07-6147 to request an SIME. **Failure to file and serve an SIME request timely may result in losing your right to an SIME**.

Appealing the Rehabilitation Benefits Administrator's (RBA) Eligibility Decision: If the RBA found you not eligible for reemployment benefits and you disagree with that decision, **you have 10 days from the date the RBA sent the letter to you, to file and serve a petition appealing this denial to the Board**. Use Form 07-6111 to file an appeal. **Failure to file and serve a petition appealing the RBA's decision timely may result in lost reemployment benefits.**

Appealing the RBA's Reemployment Plan Decision: If the RBA denies your reemployment plan and you disagree with that decision, **you have 10 days from the date the RBA sent the letter to you, to file a Petition with the Division and appeal this denial to the Board**. Use Form 07-6111 to file an appeal. **Failure to file a Petition with the Division appealing the RBA's retraining plan decision timely may result in lost reemployment benefits.**

Appealing the RBA's Non-Cooperation Decision: If the RBA decides you were non-cooperative with the reemployment process and you disagree with that decision, **you have 10 days from the date the RBA sent the letter to you, to file a petition with the Division and appeal this decision to the Board**. Use Form 07-6111 to file an appeal. **Failure to file a petition with the Division appealing the RBA's decision timely may result in lost benefits.**

Notifying the RBA if You Want to Use Reemployment Benefits. If the RBA finds you **eligible** for reemployment benefits, **you must elect** to use those benefits, participate in the stay-at-work benefits program **or** take a job dislocation benefit instead. **You must make your election within 10 days of the date you received the RBA's notification**. The RBA will send you election form 07-6153 for this purpose. **Failure to make your election timely may result in lost benefits**.

Suing a Third-Party for Your Injury: If a third-party caused your work injury and you decide to sue them in court, you **must give the Division and your employer written notice within 30 days of the date you file your law suit**. Talk to your third-party attorney about this. If you or your representative **dismisses** or **settles** your third-party case **without your employer's written consent**, you may have **waived** your right to additional workers' compensation benefits and your employer may recover the benefits it had paid to you for your work injury before you dismissed or settled your third-party case!

Changing Your Attending Physician: You may change your attending physician **once** without your employer's consent. **Notice of a change in your attending physician must be given to the employer before the change**. Referral by your attending physician to a specialist is not considered a change.

Modifying a Board Decision and Order: If something has changed in your situation or if you think the Board made a **factual** mistake in its Decision and Order (D&O), you may file and serve a petition with the Division asking the Board to modify its D&O. **You must file and serve your petition with the Division within one year after your employer last paid you disability or impairment benefits, or one year after the Board rejected your claim, whichever is later.** Use Form 07-6111 to file your modification petition. **Failure to file and serve a petition for modification with the Division timely may result in your petition being denied, and in lost benefits.**

Reconsidering a Board Decision and Order: If you think the Board made a **legal** mistake in its D&O, you may file and serve a petition asking the Board to reconsider its D&O because you think it used an incorrect legal analysis. You must file and serve your petition **within 15 days** from the date the Division served the D&O on you. Be aware that the Board's authority to reconsider its D&O **expires on the 30th** day after it served the D&O on the parties. Therefore, if you have not heard back from the Board on your petition for reconsideration, **you may seek higher review** by filing and serving a petition for review or an appeal in accordance with the next paragraph.

Seeking Higher Review of a Board Decision and Order: Your right to seek review of a Board decision by the Alaska Workers' Compensation Appeals Commission (Commission) is stated on the bottom of every Board D&O. Read the instructions carefully. **Failure to petition the Commission for review of a non-final D&O, or to appeal a final D&O to the Commission timely, may result in lost benefits**.

III. FILING DOCUMENTS WITH THE DIVISION

Division files for injured workers are created and kept electronically. Many printable forms are available on the Division's website for your use, and may be filed at any Division office in-person, by facsimile, mail or email. You are encouraged to file your pleadings and evidence by email; emailed documents must be filed as attachments in .pdf format at workerscomp@alaska.gov, and may not exceed 10 megabytes (MB). All filings **must include proof of service on all parties**. **Facsimile and email filings are considered complete and received upon** the Division's **receipt of the entire document before 5:00 PM Alaska time** on the filing date. Give yourself plenty of time and make sure your facsimile or electronic filings are **received in their entirety before 5:00 PM**. **Failure to file documents with the Division with proof of service on all other parties timely may result in you missing a critical deadline, which may result in your arguments and evidence not being considered, and in lost benefits**. Remember, deadlines are just that, deadlines! **Do not wait to the last minute to file your documents with the Division!** You can file documents at any time **before** the deadline. Do not forget to serve copies of everything you file with the Division (except for your claims), on all other parties involved in your claim.

IV. WORKERS' COMPENSATION FRAUD

Do not lie about your health or physical condition on job applications! Do not lie about anything having to do with a work injury! Dishonesty may be considered workers' compensation fraud. **You and anyone who assists you in committing workers' compensation fraud may be civilly liable and may be required to pay triple damages and attorney fees and litigation costs to the prevailing party. You may also be held liable in criminal court.**

Employer's and the representatives may also commit workers compensation fraud! A person who (1) knowingly makes a false or misleading statement, representation, or submission related to a benefit under this chapter; (2) knowingly assists, abets, solicits, or conspires in making a false or misleading submission affecting the payment, coverage, or other benefit under this chapter; (3) knowingly misclassifies employees or engages in deceptive leasing practices for the purpose of evading full payment of workers' compensation insurance premiums; or (4) employs or contracts with a person or firm to coerce or encourage an individual to file a fraudulent compensation claim is civilly liable to a person adversely affected by the conduct, is guilty of theft by deception and upon conviction may be punished by a fine up to $50,000, imprisonment up to 10 years, or both. **Suspected Workers' Compensation fraud should be reported to the Workers' Compensation Fraud Hotline at 1- 888-372-8330.**

V. WHEN YOU ARE INJURED

- Get medical care immediately. You may choose your physician. Before changing physicians, read "**Changing Your Attending Physician,"** above, and the related bullet point below.

- Tell your supervisor, employer or "the office" about the injury right away, **but no later than 15 days** after the accident, or no later than 15 days after you discover that you have an injury or illness caused by work. **Ask your employer to give you the injury report so you can do it in writing**!

- If your employer refuses to cooperate **or is not insured** for work injuries, contact the Division

immediately.

- Write down the names, addresses and phone numbers of anyone who saw your accident or the work conditions that may have caused your injury or illness.

- Get treatment from **one** licensed doctor. Give the doctor your employer's official name and address and the insurer's name and address. Ask your doctor to forward a report to the insurer and the Division **within 14 days of treatment**. Give the insurer your doctor's name and address right away.

- You may **change** your attending physician **once**. However, before you change doctors, tell the insurer that you are making a change. If you change doctors more than once without the insurer's written consent, the insurer may not have to pay the doctor's bills, and the Board may not consider that doctor's medical opinions.. If your treating doctor **refers** you to a specialist, this is **not** a change of doctors. If you move more than 50 miles away, you may choose substitution physician to be your new attending physician.

- **Keep receipts** for medicine, medical bills you paid, **actual travel expenses** (including a mileage log) and other costs of your medical care. Give copies of the receipts and the mileage record to the insurer for reimbursement; **keep copies of everything you give your adjuster with proof of service in case a dispute arises**, and you have to file a claim with the Division. **If you do not keep receipts, you may not be eligible for reimbursement.**

If your injury keeps you from working for more than three calendar days, forward copies of your W-2 forms, wage stubs, or other written records proving your earnings **to the insurer**. The insurer uses this information to calculate your weekly disability compensation rate. Employer provided room and board, contributions to pension plans and other employer provided benefits may be used in calculating your disability benefit rate. Provide the insurer with proof of employer contributions as soon as possible.

- Take good care of yourself! Get needed treatment, follow your doctor's advice, and act reasonably. Make every reasonable effort to get well and go back to work.

- Immediately tell the insurer when you **go back to work**, **get unemployment benefits**, **file for Social Security benefits** or **change your address**.

- Contact the Division if you are not paid what you think you are owed.

- Keep records of all phone calls and letters between you and the insurer.

The insurer usually learns of your injury from a Report of Injury which it receives from your employer. Within 21 days after the employer learns of your injury, the insurer must either begin to pay past and continuing workers' compensation benefits or controvert (deny) them. If the insurer denies benefits, it must send you and the Division a Controversion Notice. The notice will explain why your benefits were denied and how to file a written claim with the Division should you dispute the denial.

Compensation is payable only for **accidental injuries which arise out of and in the course of your employment**. If the insurer does not believe your injury arose out of and in the course of your employment,

it may controvert benefits. In addition, benefits **are not payable for an injury** (1) proximately caused by an employee's willful intent to injure or kill any person; or (2) proximately caused by intoxication of the injured employee or proximately caused by the employee being under the influence of drugs unless the drugs were taken as prescribed by the employee's physician as the result of a work-related injury.

VI. THIRD-PARTY INJURIES

Did your work injury arise from an incident with someone who was not your coworker -- for example a motor vehicle accident? This is referred to as a "third-party" case. You have a right to sue the third-party in civil court in addition to obtaining your workers' compensation benefits. However, your workers' compensation insurer has the right to recover the benefits it paid you under the Alaska Workers' Compensation Act (Act) from the settlement or judgment you may get from your third-party case. **Before you agree to settle any third-party case, you must get the workers' compensation insurer's written consent to the settlement. Even if the "settlement" results in no money to you (for example, you decide to dismiss your civil court case) this is considered a "settlement." Failure to get the insurer's written consent to any third-party settlement may result in the workers' compensation insurer suing you to recover the benefits it paid to you, or on your behalf, and may result in lost benefits**.

VII. PRIVACY

With limited exceptions, medical and rehabilitation records, your name, address, Social Security number, electronic mail address and telephone number in your Division file are not public records subject to public inspection and copying under AS 23.30.107. For specific privacy issues, call a Technician at a Division office.

VIII. YOUR COMPENSATION RATE

If you are unable to work and your injury has not been controverted, you should receive a check every two weeks representing your disability benefits. The amount of the check will depend on your gross weekly earnings, which are calculated in various ways depending on whether you are paid by the week, month, year, day or hour. **To determine your weekly compensation rate for temporary total disability**, go to the Division's website at https://labor.alaska.gov/wc and to the "Quick Links" drop-down menu on the right. Click on "Benefits Calculator" and select "Temporary Total Disability" from the "Type of Benefits" drop-down menu. Type in your injury date. Then type in your "Gross Weekly Wage" in the box and select your marital status and your number of dependents. Always **count yourself** as a dependent. Push the "Calculate Benefit" button and the calculator will tell you your weekly temporary disability benefit!

How do you determine your "Gross Weekly Wage"? Most workers are paid by the hour. If your earnings on your injury date were calculated by the day, hour, or by your output, your gross weekly wages are 1/50 of the total wages that you earned from all occupations during either of the two calendar years immediately preceding your injury, whichever is most favorable to you. If you were injured before November 7, 2005, or if your earnings at the time of your injury were calculated in some other way than hourly, contact the Division for information on how to calculate your "Gross Weekly Wage." If your work was seasonal or temporary or if you were a minor, apprentice, a trainee in a formal training program or a volunteer first-responder, contact the Division for more information.

Your weekly compensation rate cannot exceed the Maximum Weekly Compensation Rate or fall below the Minimum Weekly Compensation rate; these rates change annually. The Division's "Benefits Calculator" will tell you if these limits apply to your case. If you give the insurer proof of your earnings, the insurer must pay you at least 22% of the maximum compensation rate per week. If you do not give the insurer proof of your earnings, it must pay you at least $110 per week. There are exceptions when the insurer may pay less than the minimum rate. **If you believe your insurer is paying you a rate that is too low, you may file a claim for a compensation rate adjustment, using form 07-6106. If you file a rate adjustment claim, you must file evidence with the Division supporting a higher disability rate and serve your evidence on the employer's representative. For example, you may have had part-time jobs in the two years before your injury, but on your injury date you may have been working at a permanent, full-time job for several months with much higher pay. This may justify a higher weekly compensation rate!**

If you move from Alaska or live outside Alaska, the insurer must adjust your compensation rate to reflect a cost-of-living adjustment. However, if you leave Alaska for medical or reemployment services not available in Alaska, you must be paid at your Alaska weekly rate. The Division has a formula for calculating the cost-of-living adjustment. If you disagree with the cost-of-living adjustment calculated by the adjuster, you may file a claim with the Division and ask the Board to calculate the cost-of-living adjustment.

IX. PAYMENTS

No compensation benefits are paid for the first three days of disability unless you are ultimately disabled more than 28 calendar days. If you have been disabled more than 28 days, the insurer is required to then pay compensation benefits for the first three days of disability.

Compensation benefits are paid directly to you or your medical providers or, in the case of a deceased worker, to your eligible dependents. The first payment is due 14 days after the employer has knowledge of the injury or death. The insurer must pay disability or death benefits every 14 days thereafter. On or before each due date, the check should be mailed or given to you. Cashing a check does not close your claim.

If payment is not made by the 7th day **after** payment is **due**, an additional amount commonly called a "penalty" equal to **25**% of the amount then due must be paid to you by the insurer. If a payment was not paid when it was due, the insurer also owes you interest at the rate set by law. Payment is complete when placed in an envelope bearing the correct name and address of record and postmarked in the mail.

No penalties are assessed, however, if: (a) the insurer files a controversion notice within 21 days after the employer knew about your injury; (b) the insurer files a controversion notice within 21 days after your last check was due; or (3) the insurer shows the late payment was caused by something beyond its control. In some cases, even if the insurer controverts your claim, you may still be entitled to a penalty. Contact the insurer or the Division is you believe a penalty is due.

X. BENEFITS

DISABILITY AND IMPAIRMENT BENEFITS: There are three types of disability benefits and one impairment benefit:

Temporary Total Disability (TTD) benefits are paid every two weeks at your weekly compensation rate until you are medically stable or can return to work, whichever occurs first. A person reaches medical stability when no further objectively measurable improvement from the injury's effects is expected from additional medical care.

Temporary Partial Disability (TPD) benefits are paid if you can return to work but only for less than a full day while recovering, or even full-time but at less hourly wages then you were making before your injury. TPD benefits are paid every two weeks and are calculated by taking 80% of the difference between your spendable weekly wage before your injury and your spendable weekly wage after returning to work. You must give proof of your actual wages each week to the insurer to obtain TPD benefits. TPD benefits are paid until you reach medical stability or for up to five years, whichever comes first.

Permanent Total Disability (PTD) benefits are paid if you can no longer regularly and continuously work because of your work injury. Loss of both hands, both arms, both feet, both legs, both eyes or any two such injuries amounts to PTD unless you can actually earn a regular income. All other cases are decided on the nature of the injury, degree of physical impairment, age, education, work history, ability to be retrained and availability of suitable work in your area of residence, area of last employment, the state of your residence and the State of Alaska. Your ability to do some work does not necessarily disqualify you from PTD benefits if you can only do "odd jobs." Your weekly PTD benefits may be paid at a different rate than your TTD benefits if your gross weekly earnings at the time of your injury do not fairly reflect your earnings while disabled. PTD benefits are paid until your disability ends or until your death. If you received PPI benefits, your PTD benefits may be reduced by the amount of the PPI award, adjusted for inflation.

Permanent Partial Impairment (PPI) benefits may be paid in addition to TTD and TPD benefits and are paid to compensate you for permanent physical loss, like amputation, or loss of use of body parts or functions. When your doctor tells you that your injury is medically stable, your doctor should (or you may ask the doctor to) examine you to determine your physical loss or loss of use of a body part or function. Your doctor rates your percentage of loss. To rate your loss, your doctor must use the American Medical Association's (AMA) *Guides to the Evaluation of Permanent Impairment*, (Sixth Edition) (*Guides*).

Under the AMA *Guides,* the degree of impairment caused by your injury is rated as a percent of the whole person. Effective January 1, 2023, Alaska law set the value of a person at $273,000. If your injury occurred **before** January 1, 2023, your PPI benefits will be calculated at a lower dollar value. The insurer figures your PPI benefits by multiplying the percent of the whole person impairment assessed under the *Guides* by $273,000 (or the value in effect on your injury date). The result is paid in a lump-sum unless you are in the reemployment process. If you are in the reemployment process, PPI benefits are paid every 14 days at your weekly compensation rate just as you were paid TTD benefits until you complete the reemployment process.

Death Benefits. In the case of a work-related death, the insurer pays $12,000 for funeral expenses and $8,000 to the employee's surviving spouse and any children. In addition, weekly benefits are paid to the employee's widow, widower, and children who are dependents. Children living in the worker's household or supported by a deceased worker, regardless of parentage, may also qualify as dependents. Unmarried dependent children receive benefits to age 19 or older while they go to high school or during their first four years of trade school, technical school, or college. If there is no widow, widower, or child, then parents, grandchildren or brothers and sisters if dependent upon the deceased at the time of injury are paid 42

percent of the decedent's spendable weekly wages, "share and share alike" not to exceed $150,000 in the aggregate. All questions of dependency are determined as of the time of injury or death. Contact the Division for details about who can qualify as dependents and the weekly benefit amount.

Medical Benefits. The insurer is obligated to pay medical expenses for up to two years following the injury, but may be paid thereafter by Board order. Insurers often pay, or are ordered to pay, for medical care beyond two years if necessary for the process of your recovery.

Choice of Doctors. You may choose a licensed medical doctor, surgeon, chiropractor, osteopath, dentist, or optometrist. You may change your treating doctor once, but tell the insurer before you change. If your doctor sends you to a specialist, the referral does not count as a change of doctors. If you want to change physicians a second time, you **must** obtain the insurer's written approval. **If you change doctors more than once without the insurer's written approval, you may have to pay the doctor's bills**, and the Board may not consider the unlawful doctor's opinions if your case goes to a hearing.

Reporting. Be sure your doctor prepares a report on a "Physician's Report" form 07-6102 for the insurer and the Division. **Unless your doctor reports that you cannot work, the insurer will not have a basis to start disability payments**. If your doctor does not have the form, ask the insurer for forms to give to your doctor. Until your doctor has the form, the doctor may send a copy of the chart notes, write a letter, or use another report form or method.

Insurer's Obligation to Pay. Provide your doctors, the hospital, or other medical providers with the insurer's name and address and **ask them to bill the insurer**. The insurer will pay covered costs directly to the billing provider. If for some reason you pay medical bills, **save your receipts** and provide them to the insurer **with proof of service, and keep a copy for yourself**. The insurer has 30 days to pay a medical bill once it receives a medical report **and** the accompanying bill. **If the insurer does not pay within 30 days, a penalty and interest may be due to the medical provider.**

The insurer's obligation to pay medical expenses is controlled by the Alaksa Workers' Compensation Medical Fee Schedule. Covered costs include doctor's and nurse's fees, hospital and physical therapy charges, prescribed medicine, crutches, artificial limbs, dentures, glasses, hearing aids, medical supplies, ambulance charges, reasonable transportation costs to and from the nearest place of treatment for your injury, and reasonable meal and lodging costs when you must be treated away from your home city.

Limits on Frequency of Treatment. Payment for repeated treatments of the same kind, such as physical therapy or chiropractic care, is limited. The insurer usually will not have to pay for outpatient treatment exceeding three times per week for the first month, two times per week for the second and third months, once a week for the fourth and fifth months, and once a month for the sixth through twelfth months. If your doctor wants to treat you more often, your doctor must submit a written treatment plan **within 14 days** of the initial treatment. **The insurer may not be required to pay the doctor if a written treatment plan is not sent to the insurer and given to you within 14 days after the first treatment. The provider may not require you to pay the bills!**

Transportation. The insurer is obligated to pay transportation expenses to the closest medical facility from your residence. You must use the most reasonable and efficient form of transportation available to travel to your medical appointments. If you must use a bus, taxi, train, or airplane to obtain medical care, **save**

receipts. If you use your own car, **write down the date, where you went and your mileage**. Provide copies of the receipts and your mileage record to the insurer, **and keep a copy for yourself with proof of service**. Mileage is reimbursed by the insurer.

If medical treatment is not available in your home city, tell the insurer before you travel so you know what will be paid. **Save receipts for meals and lodging**. To obtain reimbursement, **you must submit copies of the receipts to the insurer with proof of service; keep a copy for yourself**. Reimbursable expenses may not exceed the *per diem* amount paid by the State of Alaska to its supervisory employees while traveling.

Medical Examinations Requested by the Insurer. At reasonable times, which may be as often as every 60 days, the insurer **can require** that you be examined by a doctor of its choice. The insurer must give you at least 10 days' notice of the medical appointment. If for some reason you object to seeing the employer's doctor, you may file and serve a petition-for-a-protective-order.

The insurer may change its examining doctor only **once**, unless you agree in writing to see a different doctor. Referral by the insurer's doctor to a specialist does not constitute a change of the insurer's doctor. A "panel" examination is appropriate so long as you see each physician within five days of each other. The insurer pays all costs associated with the examinations. **If you do not go to the examination, the insurer may terminate your compensation benefits until you see its doctor**.

Examinations Ordered by the Board. If your doctor and the insurer's doctor disagree about your case, either party may request, and the Board may select, a physician or physicians to examine you at an SIME. The insurer must pay the costs of this SIME and your reasonable transportation and lodging expenses. **Your compensation benefits may be reduced to repay the insurer for the doctor's fee and other costs associated with this examination if you fail to attend the examination and the Board finds good cause did not exist for your failure to attend**.

XI. REEMPLOYMENT BENEFITS

Reemployment benefits are a benefit (if found eligible) that is provided to an injured worker when they are not able to return to their job of injury or to any of the jobs they held during the ten-year period prior to their injury. Reemployment means retraining to a different job that does not require the same permanent physical capacities required from your job of injury or any of the jobs you held during the ten-year period before your injury. If you have been determined to be eligible for reemployment benefits you may accept a dislocation benefit instead of retraining.

Reemployment benefits eligibility evaluation (evaluation) is a process in which the reemployment benefits office assigns a rehabilitation specialist to gather information about your injury, job at the time you were injured, jobs you have held in the 10 years prior to the time you were injured, any jobs you have held since you were injured, education/training, medical provider, and any work related injuries you have experienced. A rehabilitation specialist is a specialist certified by either the Commission on Rehabilitation Counselor Certification, Disability Management Specialists Commission, or who has equivalent or better qualifications.

****If you were injured January 1, 2025 or later****

If your injury is after this date and you have been totally unable to return to your job of injury for 25 consecutive days, the Reemployment Benefits Section (RBS) must notify you of your rights regarding

reemployment and Stay-At-Work benefits. If you select stay-at-work benefits and your employer opts in, you will be assigned a rehabilitation specialist who will assist you in returning to work with your employer. A Stay-At-Work plan will be developed and may consist of job accommodations, training, or a combination of these elements. The Stay-At-Work plan must be prepared within 60 days by the rehabilitation specialist and submitted to the Stay-at-Work Program Coordinator. The Stay-at-Work Program Coordinator must approve or deny the plan within 14 days. If, however, you or your employer disagree with the plan, either of you may submit the plan to the Reemployment Benefits Administrator (Administrator). The Administrator has 14 days to approve or deny the plan. Within 10 days of the Administrator's plan approval or denial, you or the insurer may ask in writing for the Board to review the Administrator's decision.

If you do not choose Stay-At-Work benefits and elect reemployment benefits, or your employer opts out of the Stay-At-Work process, you will continue in the reemployment benefits process by having the rehabilitation specialist perform an evaluation. Likewise, if you have been totally unable to return to your job at the time of injury for 120 consecutive days as a result of the injury, the Administrator is required to assign a rehabilitation specialist to conduct an evaluation.

Please call the RBS at (907) 269-4985 if you have not received notification in the timeframes noted above or if you have questions or concerns regarding stay-at-work or reemployment benefits.

****If you were injured between November 7, 2005 – December 31, 2024****

If your injury is between these dates and you have been totally unable to return to your job of injury for 45 consecutive days, the RBS must notify you of your rights regarding reemployment benefits.

If you have been totally unable to return to your occupation at the time of injury for 60 to 89 consecutive days, you or the insurer may request an evaluation to determine your eligibility for reemployment benefits. Medical documentation that shows your injury permanently prevents you from returning to your occupation at the time of injury must be included with the request.

If you have been totally unable to return to your occupation at the time of injury for 90 consecutive days as a result of the injury, the Administrator is required to assign a rehabilitation specialist to conduct an evaluation. At any time, you and the insurer may agree that you are eligible for retraining without an evaluation through a stipulation to eligibility for reemployment benefits. The parties may fill out Form 07-6152 and have it notarized and submit it to RBS.

Please call the RBS at (907) 269-4985 if you have not received notification in the timeframes noted above or if you have questions or concerns regarding reemployment benefits.

****If you were injured prior to November 7, 2005****

If your injury is before November 7, 2005, please contact the RBS at (907) 269-4985.

Disability and stipend benefits while in the reemployment process: Regardless of where you are in the rehabilitation process, you will receive temporary total disability (TTD) benefits until you reach medical stability. At that time TTD benefits will be terminated, and permanent partial impairment (PPI) benefits will be paid every two weeks at your TTD rate until either PPI benefits have been paid in full or until you are no longer involved in the reemployment process (you have either completed the vocational plan or opted out of reemployment benefits). Any remaining PPI benefits due when the reemployment process is complete are paid in a lump sum. If, however, you are still in the reemployment process when all PPI benefits have been paid, the insurer must pay a stipend equal to 70% of your spendable weekly wages

(87.5% of your TTD benefit), but not more than 105% of your average weekly wage. Stipend benefits can be paid for no more than two years and will terminate when you are no longer in the reemployment process.

Waiver of reemployment benefits: You may waive your reemployment benefits any time after a physician has determined you are medically stable. To waive reemployment benefits you must fill out Form 07-6168, have it notarized and submit it to the insurer, RBS, and the Division.

Reemployment responsibilities: If you are referred by the RBS for an evaluation, you must cooperate and assist with the evaluation. You will be assigned to a rehabilitation specialist, and they must complete the reemployment benefits eligibility evaluation and write a report regarding your eligibility for reemployment benefits. The insurer pays all costs associated with the rehabilitation specialist.

After the RBS receives the evaluation report from the rehabilitation specialist the Administrator or its designee must issue within 14 days a written decision regarding your eligibility for reemployment benefits.

You may be eligible for reemployment benefits if:

(a) A medical provider predicts you will never be able to return to your job at the time of injury and other jobs that you have held or received training/education for since your injury or in the ten years prior to your injury;

(b) Your employer does not offer you appropriate alternate employment;

(c) You have not been previously retrained or received a dislocation benefit in a previous claim and then returned to a job with the same or similar physical demands; and

(d) A medical provider predicts that you will have or do have a permanent partial impairment rating as a result of your injury.

If you are **not found eligible** for reemployment benefits, within 10 days after the decision you may appeal the decision and ask for review of the decision by requesting a hearing under AS 23.30.110. Instructions and forms will be included in each determination letter.

If you are **found eligible**, you must choose whether to pursue retraining or receive a dislocation benefit instead. The Administrator's letter includes a form for you to indicate your choice. Should you decide to waive retraining in favor of a dislocation benefit, you will receive a sum of money in the amount of either $5,000, $8,000 or $13,500 depending on your permanent partial impairment rating.

If you choose to pursue retraining, you must give written notice to the insurer and the Administrator of your choice of a rehabilitation specialist within 30 days after receiving notice of your eligibility or your reemployment benefits may be forfeited. The Administrator's letter includes a list of rehabilitation specialists from which you must choose to help you develop a retraining plan. The plan must be prepared within 90 days of the Administrator's assignment of the rehabilitation specialist you have selected.

If you, the insurer, and the rehabilitation specialist agree to a plan, you all must sign the plan. You then proceed with the plan. If, however, you or the insurer disagree with the plan you have selected, either of you may submit the plan to the Administrator. The Administrator has 14 days to approve or deny the plan. Within 10 days of the Administrator's approval or denial of the plan, you or the insurer may ask in writing for the Board to review the Administrator's decision.

You must cooperate and remain in contact with your rehabilitation specialist, take part in activities relating to reemployment, keep all appointments, maintain passing grades if in school and attend all programs as identified in the plan. If you unreasonably fail to perform these responsibilities, you may be deemed to

have failed to cooperate with reemployment and the insurer may terminate reemployment benefits. If you disagree with the termination, you must ask the Administrator in writing to hold a hearing to decide whether you have failed to cooperate

IF YOU HAVE QUESTIONS ABOUT REEMPLOYMENT BENEFITS, PLEASE CONTACT THE REEMPLOYMENT BENEFITS OFFICE AT (907) 269-4985.

XII. GLOSSARY OF TERMS

AFFIDAVIT OF READINESS FOR HEARING (ARH). Form 07-6107. The official form used to schedule a hearing on a claim or petition.

AFFIDAVIT IN OPPOSITION TO AFFIDAVIT OF READINESS FOR HEARING. Form 07-61**. This form may be used to oppose another party's ARH, if a party is not ready for a hearing.

AFFIDAVIT OF SERVICE. A statement by an individual under oath that they served certain documents on the parties listed.

ALASKA SUPREME COURT (Court) This is the highest court in the state, which hears petitions for review and appeals from Commission decisions. This is a party's last resort if they are unhappy with a Board or Commission decision.

ALASKA WORKERS' COMPENSATION ACT (Act). The statutes that define the rights, benefits and obligations of employers and employees with respect to work-related injuries.

ALASKA WORKERS' COMPENSATION APPEALS COMMISSION (Commission). The group of governor-appointed industry and labor members who, along with a chairperson, hears and decides petitions for review and appeals from Board decisions.

ALASKA WORKERS' COMPENSATION BENEFITS GUARANTY FUND (the Fund). This is a group within the Division that may pay your benefits from a special fund in the event your employer did not have workers' compensation insurance when you were injured, were ordered to pay you, but did not.

ALASKA WORKERS' COMPENSATION BOARD (Board). The group of governor-appointed industry and labor members who, along with a Division Hearing Officer in a two- or three-person panel hear and decide workers' compensation claims and petitions. The Board as a group also considers and approves regulations drafted by the Division. Neither the Board nor the Division pay benefits.

ANSWER. The document filed in response to a Claim or a Petition.

CLAIM. Form 6106. Formally entitled a Claim for Workers' Compensation Benefits, this is the document filed by an injured worker, or other party who may have a right to payment, to request benefits. A claim commences an action before the Board. A Medical Summary must accompany this form. A Request for a Prehearing Conference may be filed with this form.

COMPROMISE AND RELEASE (C&R). A written settlement agreement among parties that resolves all or some issues in the case. If you are not represented by an attorney, the Board must approve the agreement for it to be binding on the parties.

CONTROVERSION NOTICE. A notice sent by the insurer stating they will not pay for the benefits listed, and the reasons why they will not pay. This denial of benefits can be appealed to the Board by filing a Claim along with a Medical Summary with the Division.

COVERAGE. Nearly all Alaska employees are covered under the Act. Commercial fishers are an exception, but some fish processing workers on floating processing vessels are covered. Other employees not covered include independent contractors, contract entertainers, some taxicab drivers, part-time babysitters, some cleaning persons, some participants in the Alaska Temporary Assistance Program, some sports officials, harvest help and some realtors. Most unpaid volunteers are not covered, but some volunteer ambulance attendants, volunteer fire-fighters and police officers, volunteer emergency medical technicians, and volunteer civil defense or disaster workers are covered. Sole proprietors and partners of businesses, executive officers of non-profit corporations, and members of a limited liability company (LLC) are not covered but may choose to be included in coverage. Executive officers of for-profit-corporations are covered but may choose to waive coverage by obtaining an executive officer waiver from the Division. Although federal employees and most maritime workers are not covered under Alaska law, they may be covered under federal law. If you have questions about whether you are covered, please contact the Division.

DECISION AND ORDER (D&O). This is the Board's ruling on a claim or petition. If a party disagrees with a D&O, they may file and serve a Petition for Reconsideration or a Request for Modification. Alternately, if the D&O is "Interlocutory" (non-final) a party may seek review from the Commission by filing and serving a Petition for Review with the Commission. If the D&O is "Final," a party may file and serve an appeal to the Commission, but such actions must be within the time limits prescribed by law.

DIVISION OF WORKERS' COMPENSATION (Division). This group is part of the Alaska Department of Labor. The Division maintains case files, and collects and provides information about the workers' compensation system and benefits, and provides administrative support for the Board. **When this pamphlet directs you to "file" something it is generally referring to filing it with the Division**. Some documents are filed with the Commission or the Alaska Supreme Court, as indicated in this pamphlet.

ENTRY (OR NOTICE) OF APPEARANCE. A document notifying the parties that an attorney, or other representative, is entering the case on behalf of a party. If you want someone to represent you before the Board or before a Board designee, and speak on your behalf at a prehearing conference or a hearing, that person must file and serve an appearance.

EVIDENCE: Any document that you want the Board to consider at a hearing, including but not limited to photographs, medical records, itemized medical bills, receipts for out-of-pocket expenses, witness statements, and affidavits, all constitute "evidence" that may be admissible before the Board at a hearing. **Be sure to file and serve all your evidence within the deadline set forth in the administrative regulations or set by the Board designee in a prehearing conference summary**. **Failure to timely file and serve your evidence may result in the Board not considering it**.

INJURY. An accidental injury or illness caused by work. "Injury" may include a preexisting condition that work aggravated, accelerated or combined with to cause time-loss or the need for medical treatment. "Injury" may also include a mental-health condition caused or aggravated by your work.

INSURER. The insurance company or a self-insured employer. The insurer through its adjuster either pays or denies (controverts) your benefits.

LEGAL MEMORANDA (Brief). A document a party files and serves, which identifies issues, presents arguments and cites applicable law. A brief may be as simple as a letter setting forth your position and stating why you think you should receive benefits or otherwise "win" your petition or claim.

MEDICAL STABILITY. The date after which further objectively measurable improvement from the effects of an injury is not reasonably expected to result from additional medical care or treatment, notwithstanding the possible need for additional medical care or the possibility of improvement or deterioration resulting from the passage of time. Medical stability is presumed in the absence of objectively measurable improvement for a period of 45 days. Temporary disability benefits terminate once your condition becomes medically stable. Your physician may rebut your presumed medical stability by providing an opinion that you are not yet medically stable and would benefit from additional medical care.

MEDICAL SUMMARY. Form 07-6103. A listing of medical records in a case. This document must accompany a Claim. You should obtain, file on a medical summary and serve all your relevant medical records upon which you want the Board to rely on at a hearing. **Do not rely on your employer or its representatives to obtain and file your medical records**. **Your signed medical release authorizes your employer to obtain your medical records, but does not require your employer to do so.**

OPPOSITION TO AFFIDAVIT OF READINESS. A document a party files to oppose the scheduling of a hearing as requested in an ARH. The opposition must state why a hearing should not yet be set.

PETITION. Form 07-6111. A request to the Board for some Board action in your case, other than a request for benefits.

PHYSICIAN'S REPORT. Form 07-6102. A document your doctor files directly with the Division reporting your medical condition, recent treatment, future treatment plans and more.

REEMPLOYMENT BENEFITS ADMINISTRATOR (RBA). The RBA decides reemployment benefit eligibility, reviews retraining plans and stay-at-work programs and hears initial disputes between you and the insurer regarding reemployment benefits. You may appeal the RBA's decisions to the Board.

REQUEST FOR CROSS-EXAMINATION: Form 07-6174. This form is used to request and protect your right to cross-examine the author of medical or non-medical documents filed and served by other parties to your claim. For example, if you want to ask the employer's physician questions about his report, or you want to ask a witness about her statements made in an affidavit filed with the Division, you may use this form to protect your right. In most circumstances, if you file this report and the opposing party does not give you an opportunity either in a deposition before hearing, or at a hearing before the Board, to ask the subject person questions, the Board may not consider the medical report or non-medical evidence. **There are deadlines for filing and serving a request for cross-examination. Contact the Division for information about these**

deadlines. Failure to timely request cross-examination may result in the Board considering the evidence without your employer providing you an opportunity to question the person offering the document.

REPORT OF OCCUPATIONAL INJURY OR ILLNESS. The first written notice of an injury that you give to your employer or your supervisor and your employer files electronically with the Division. It establishes when and how an injury occurred. Immediately upon being injured at work, you should ask your employer to give you this report to complete in writing. **You should obtain and keep a completed, signed and dated copy for yourself**.

REQUEST FOR CONFERENCE. This is a request to the Division to schedule an informal prehearing conference to resolve a particular issue or discuss and identify the issues filed on a Claim or Petition.

SECOND INDEPENDENT MEDICAL EVALUATION (SIME). When your physician and the insurer's physician disagree on the nature or extent of the injury or illness, a party may request an examination by a Board-selected physician or physicians.

SERVICE AND PROOF OF SERVICE: This refers to your obligation to serve on all parties to your claim any document that you file with the Division. Even if you do not intend to rely on a document at hearing, if you file it with the Division you must serve it on all parties. "Proof of service" means a statement or affidavit of service accompanying your filed documents stating that you served on all parties to your claim a complete copy of the documents that you filed with the Division. **Failure to serve documents on all parties to your claim, with proof of service stating the date and means by which you served it, may result in your documents including evidence not being considered by the Board at a hearing, which may result in lost benefits.**

SPECIAL INVESTIGATIONS UNIT (SIU). This unit within the Division investigates and civilly prosecutes uninsured employers before the Board. The SIU may investigate workers' compensation fraud. It also provides outreach to employers to teach and inform them about the Act's requirements for insurance coverage for workers.

STIPULATION. A written or oral agreement between parties on a specific issue. Stipulations may require a Board order to be valid.

XIII. OTHER IMPORTANT INFORMATION

RECORD KEEPING. Keep track of and understand the payments the insurer makes. Keep a record of letters and phone calls between you and the insurer. If you have questions about your rights, benefits, or whether the insurer has paid all the benefits due, contact the nearest Division office or an attorney familiar with Alaska workers' compensation law. Call the Division for a list of such attorneys.

WHAT TO DO IF YOUR EMPLOYER IS UNINSURED. If your employer does not have workers' compensation insurance, notify the Division's SIU immediately. If your employer agrees to pay benefits, get the agreement in writing. If the employer refuses to pay benefits, file a claim with the Division against your employer. The Division will serve a copy of your claim on your employer and on the Fund. If the Board finds your employer liable for your benefits and fails to pay them, the Fund will pay your benefits and seek recovery from your employer. To qualify for benefits from the Fund, the following conditions

must be met:

(1) You must have been an employee of an uninsured employer at the time of injury.
(2) Your work for your employer must have been the substantial cause of your disability or need for medical treatment.
(3) You must file a claim for benefits against your uninsured employer and the Fund within two years of the injury, or two years of your knowledge that an injury or illness was work-related.
(4) Your claim must result in a Board order for your employer to pay your benefits.
(5) Your employer must fail to pay as the Board ordered.

RELEASES. If you want your benefits to continue, you must give the employer written authorization to obtain medical and rehabilitation information regarding your injury and any previous medical records relating to the same body parts or functions as those injured. **If you are asked to sign a release that you feel is not appropriate, you must file a petition for a protective order with the Board within 14 days after you receive the release.** If you do not file for a protective order and refuse to sign the release, or if you refuse to sign the release after being ordered to sign it by the Board, **your benefits will be suspended and may be forfeited.**

INSURER'S RESPONSIBILITIES. The insurer must follow the Alaska workers' compensation laws in dealing with you and your claim. The insurer must also comply with Alaska's insurance laws. The State of Alaska, Division of Insurance handles complaints about insurers. If you are not represented by an attorney, the Division of Insurance requires the insurer to give you necessary claim forms, written instructions, and reasonable help so you can comply with the law and with claim-handling requirements. For more information about Alaska insurance laws, contact the State of Alaska, Division of Insurance at P.O. Box 110805, Juneau, Alaska 99811-0805, (907) 465-2515 or in Anchorage at 3601 C Street, Suite 1324, Anchorage, Alaska 99502-5948, (907) 269-7900, or in-state toll free number (800) 467-8725.

UNEMPLOYMENT BENEFITS. You may not receive temporary total or permanent total disability benefits while you are receiving unemployment benefits. If you receive unemployment benefits while you are receiving disability benefits, tell the insurer right away. However, if you repay unemployment benefits, you may be entitled to workers' compensation benefits.

EXEMPTIONS FROM DEBT AND TAXES. Workers' compensation benefits paid to you are not taxable. If a creditor has a judgment against you, for example child support, some creditors may take some or all of your weekly disability benefits. You can go to court to have the court decide how much of your weekly disability benefits you can keep. You may need an attorney's help.

OVERPAYMENTS AND ADVANCES. The insurer sometimes makes advance payments or overpays benefits. The insurer may keep up to 20% from each future payment until the overpayment or advance is repaid. The insurer must obtain Board approval to take more than 20% from each payment. If you question whether an overpayment or advance was made, or whether the insurer is reducing your checks by the right amount, talk to the insurer. If you still have questions, contact the Division.

APPLYING FOR WORK AFTER YOU RECOVER. After you recover and apply for work, be aware that AS 23.30.022 provides: "An employee who knowingly makes a false statement in writing as to the employee's physical condition in response to a medical inquiry, or in a medical examination, after a

conditional offer of employment may not receive benefits under this chapter if (1) the employer relied on the false representation and this reliance was a substantial factor in the hiring; and (2) there was a causal connection between the false representation and the injury to the employee."

The law prohibits an employer from discriminating against you in hiring, promoting or keeping you on the job because you filed a claim for workers' compensation benefits. The Americans with Disabilities Act (ADA), also limits prospective employers' right to ask you about your physical condition unless and until they are few a position. You can obtain information about the ADA by calling the federal Equal Employment Opportunity Commission at 1-800-669-4000, or writing the Commission at 907 First Avenue, Suite 400, Seattle, Washington 98104-1061.

SOCIAL SECURITY OFFSET. Your workers' compensation disability or death benefits may be reduced if you or your dependents receive Social Security disability or retirement benefits. You should tell the insurer when you obtain Social Security benefits.

DISPUTES REGARDING BENEFITS. If you and the insurer disagree about your right to benefits or the amount of benefits due, you may file a claim (Form 07-6106) and ask for a hearing before the Board. Contact the Division for information and forms.

SETTLEMENT OF DISPUTES. You may settle your right to benefits with the insurer at any time after achieving medical stability by entering into a written C&R. The C&R may settle a part or all of your past and future benefits. **Read the C&R carefully**. Be sure you understand what the C&R means. If you are not represented by an attorney, the C&R will not be binding until the Board approves it. The Board can approve a C&R only if it finds the C&R meets certain requirements and **is in your best interests**. **Once the Board approves a C&R, it is final**. If you are represented by an attorney, however, the C&R is final once it has been filed with the Board, as long as medical benefits are not being waived.

ATTORNEYS. You may choose to hire an attorney at any time to deal with the insurer or present your case at a hearing. An attorney will probably present the employers and insurer's case at a hearing. If you plan to hire an attorney, see her or him early in the case to help you file a claim and get ready for a hearing. The Alaska Bar Association has a referral system to help you find an attorney willing to handle workers' compensation claims or you may call the Division for an attorney list.

ATTORNEY'S FEES. If you prevail on your claim before the Board, the Board will order the insurer to pay all or part of your attorney's fees and legal costs. Your attorney cannot collect a fee of more than $300 from you for one-time advice on your case; **most attorneys charge nothing**. If you lose before the Board, your attorney gets no attorney fees. However, you may have to pay your legal costs. You never have to pay the insurer's attorney's fees and legal costs **unless you knowingly lie to get benefits**.

Helpful forms are available at http://www.labor.state.ak.us/wc/pdf_list.htm and at Division offices.

IF YOU CANNOT OBTAIN FORMS, WRITE THE DETAILS OF YOUR CLAIM IN A **LETTER TO THE BOARD, EMPLOYER AND INSURER. Be sure to put your date of injury, your full name and address and the date of the request in the letter and sign it.**

V. CONTACT US

IF YOU STILL HAVE QUESTIONS contact the nearest Workers' Compensation Division office:

ANCHORAGE:	FAIRBANKS:	JUNEAU:
3301 Eagle Street	675 Seventh Avenue	1111 W. Eighth Street
Suite 304	Station K	Room 305
Anchorage, Alaska	Fairbanks, Alaska	P.O. Box 115512
99503-4149	99701-4593	Juneau, Alaska
(907) 269-4980	(907) 451-2889	99811-5512
		(907) 465-2790

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