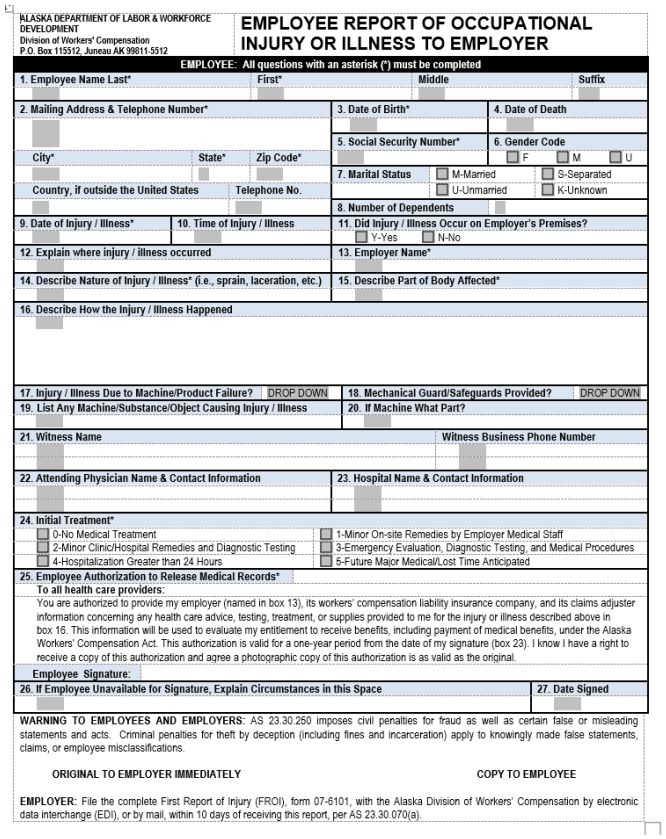

# Workers' Compensation and Employers Responsibility

Carleen Mitchell, PHR, SHRM-CP

# What is Workers' Compensation

- Workers' compensation is a form of insurance that provides wage replacement and medical benefits to employees injured in the course of doing their job.
- Workers' compensation in Alaska is an "exclusive remedy"; that is, it prohibits employees from suing their employer for the on-the-job injury if the employee is receiving workers' compensation benefit.
- It is the goal of your workers' compensation insurance provider to process each workers' compensation claim so your injured employee receives the medical care and benefits they are entitled to while protecting your organization from excessive or fraudulent claims costs.
- The information you – the employer- provides helps us meet this goal.



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

**EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER**

**EMPLOYEE: All questions with an asterisk (*) must be completed**

1. Employee Name Last* | First* | Middle | Suffix
2. Mailing Address & Telephone Number*
3. Date of Birth*
4. Date of Death
5. Social Security Number*
6. Gender Code ☐ F ☐ M ☐ U
City* | State* | Zip Code*
7. Marital Status ☐ M-Married ☐ S-Separated ☐ U-Unmarried ☐ K-Unknown
Country, if outside the United States | Telephone No.
8. Number of Dependents
9. Date of Injury / Illness*
10. Time of Injury / Illness
11. Did Injury / Illness Occur on Employer's Premises? ☐ Y-Yes ☐ N-No
12. Explain where injury / illness occurred
13. Employer Name*
14. Describe Nature of Injury / Illness* (i.e., sprain, laceration, etc.)
15. Describe Part of Body Affected*
16. Describe How the Injury / Illness Happened
17. Injury / Illness Due to Machine/Product Failure? DROP DOWN
18. Mechanical Guard/Safeguards Provided? DROP DOWN
19. List Any Machine/Substance/Object Causing Injury / Illness
20. If Machine What Part?
21. Witness Name | Witness Business Phone Number
22. Attending Physician Name & Contact Information
23. Hospital Name & Contact Information
24. Initial Treatment*
☐ 0-No Medical Treatment ☐ 1-Minor On-site Remedies by Employer Medical Staff
☐ 2-Minor Clinic/Hospital Remedies and Diagnostic Testing ☐ 3-Emergency Evaluation, Diagnostic Testing, and Medical Procedures
☐ 4-Hospitalization Greater than 24 Hours ☐ 5-Future Major Medical/Lost Time Anticipated
25. Employee Authorization to Release Medical Records*
To all health care providers:
You are authorized to provide my employer (named in box 13), its workers' compensation liability insurance company, and its claims adjuster information concerning any health care advice, 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 (box 23). 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:
26. If Employee Unavailable for Signature, Explain Circumstances in this Space | 27. Date Signed

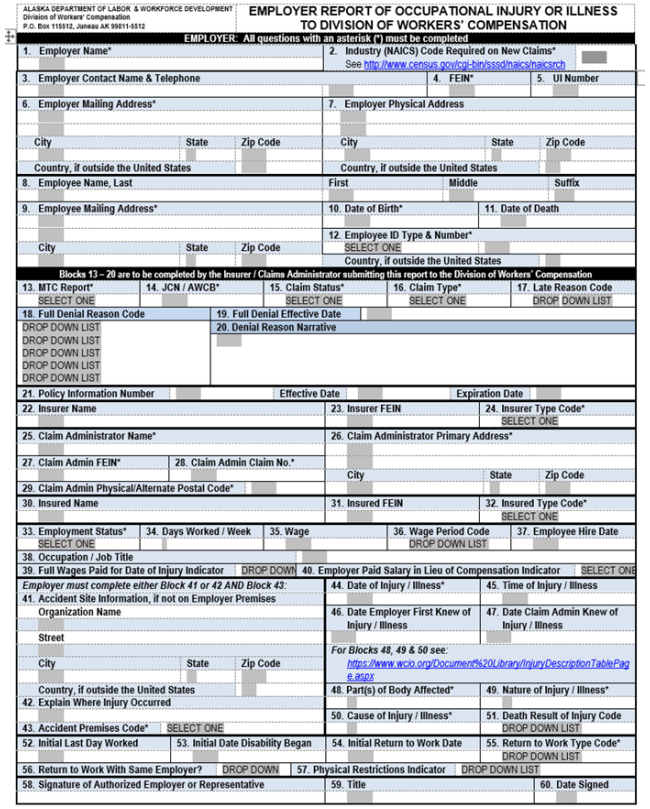
**WARNING TO EMPLOYEES AND EMPLOYERS:** AS 23.30.250 imposes civil penalties for fraud as well as certain false or misleading statements and acts. Criminal penalties for theft by deception (including fines and incarceration) apply to knowingly made false statements, claims, or employee misclassifications.

ORIGINAL TO EMPLOYER IMMEDIATELY COPY TO EMPLOYEE

**EMPLOYER:** File the complete First Report of Injury (FROI), form 07-6101, with the Alaska Division of Workers' Compensation by electronic data interchange (EDI), or by mail, within 10 days of receiving this report, per AS 23.30.070(a).

# How are worker injuries reported

- Form 6100- Employee Report of Occupational Injury or Illness to Employer
  - To be completed and signed by the employee
  - Employee provides copy of form for the employer
  - Employee should keep a copy for their records



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**EMPLOYER REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO DIVISION OF WORKERS' COMPENSATION**

**EMPLOYER: All questions with an asterisk (*) must be completed**

1. Employer Name*
2. Industry (NAICS) Code Required on New Claims*
See http://www.census.gov/cgi-bin/sssd/naics/naicsrch
3. Employer Contact Name & Telephone
4. FEIN*
5. UI Number
6. Employer Mailing Address*
City | State | Zip Code
Country, if outside the United States
7. Employer Physical Address
City | State | Zip Code
Country, if outside the United States
8. Employee Name, Last | First | Middle | Suffix
9. Employee Mailing Address*
City | State | Zip Code
10. Date of Birth*
11. Date of Death
12. Employee ID Type & Number*
SELECT ONE
Country, if outside the United States

**Blocks 13 – 20 are to be completed by the Insurer / Claims Administrator submitting this report to the Division of Workers' Compensation**

13. MTC Report* SELECT ONE
14. JCN / AWCB*
15. Claim Status* SELECT ONE
16. Claim Type* SELECT ONE
17. Late Reason Code DROP DOWN LIST
18. Full Denial Reason Code DROP DOWN LIST DROP DOWN LIST DROP DOWN LIST DROP DOWN LIST DROP DOWN LIST
19. Full Denial Effective Date
20. Denial Reason Narrative
21. Policy Information Number | Effective Date | Expiration Date
22. Insurer Name
23. Insurer FEIN
24. Insurer Type Code* SELECT ONE
25. Claim Administrator Name*
26. Claim Administrator Primary Address*
27. Claim Admin FEIN*
28. Claim Admin Claim No.*
City | State | Zip Code
29. Claim Admin Physical/Alternate Postal Code*
30. Insured Name
31. Insured FEIN
32. Insured Type Code* SELECT ONE
33. Employment Status* SELECT ONE
34. Days Worked / Week
35. Wage
36. Wage Period Code DROP DOWN LIST
37. Employee Hire Date
38. Occupation / Job Title
39. Full Wages Paid for Date of Injury Indicator DROP DOWN
40. Employer Paid Salary in Lieu of Compensation Indicator SELECT ONE

*Employer must complete either Block 41 or 42 AND Block 43:*

41. Accident Site Information, if not on Employer Premises
Organization Name
Street
City | State | Zip Code
Country, if outside the United States
42. Explain Where Injury Occurred
43. Accident Premises Code* SELECT ONE
44. Date of Injury / Illness*
45. Time of Injury / Illness
46. Date Employer First Knew of Injury / Illness
47. Date Claim Admin Knew of Injury / Illness

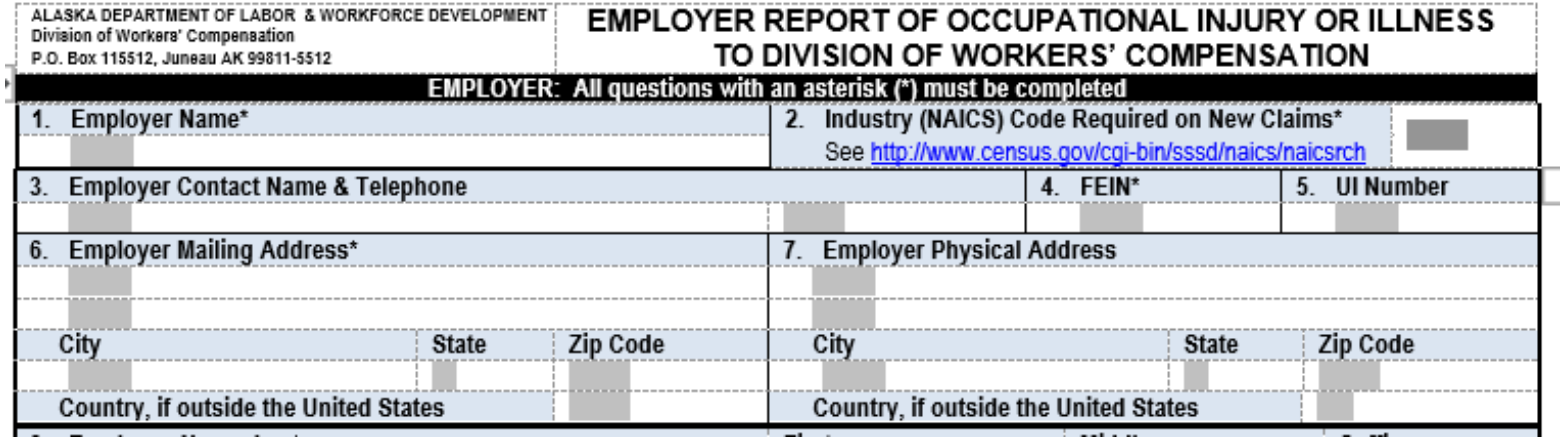
*For Blocks 48, 49 & 50 see:*
*https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx*

48. Part(s) of Body Affected*
49. Nature of Injury / Illness*
50. Cause of Injury / Illness*
51. Death Result of Injury Code DROP DOWN LIST
52. Initial Last Day Worked
53. Initial Date Disability Began
54. Initial Return to Work Date
55. Return to Work Type Code* DROP DOWN LIST
56. Return to Work With Same Employer? DROP DOWN
57. Physical Restrictions Indicator DROP DOWN LIST
58. Signature of Authorized Employer or Representative
59. Title
60. Date Signed

# How are worker injuries reported

- Form 6101- Employer Report of Occupational Injury or Illness to the Division of Workers' Compensation
- To be completed by the employer
- Must be submitted to your insurance carrier within 10 days
  - Late reports may result in penalties
  - Late reports can also delay treatment and payment of benefits to the injured worker
- *The information collected in this form is necessary for your insurance company to adequately investigate the claim and correctly determine compensation!*

# What Information Does the WC Insurance Carrier Need?



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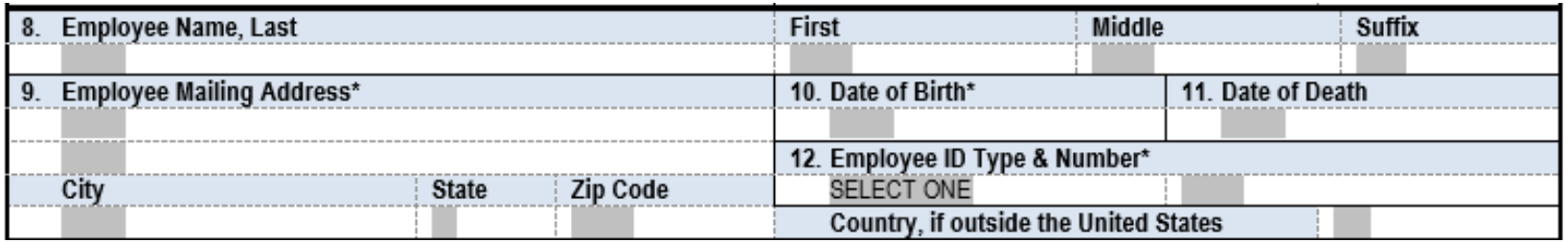
**EMPLOYER: All questions with an asterisk (*) must be completed**

| 1. Employer Name* | 2. Industry (NAICS) Code Required on New Claims* See http://www.census.gov/cgi-bin/sssd/naics/naicsrch | |
|---|---|---|
| 3. Employer Contact Name & Telephone | 4. FEIN* | 5. UI Number |
| 6. Employer Mailing Address* | 7. Employer Physical Address | |
| City / State / Zip Code | City / State / Zip Code | |
| Country, if outside the United States | Country, if outside the United States | |

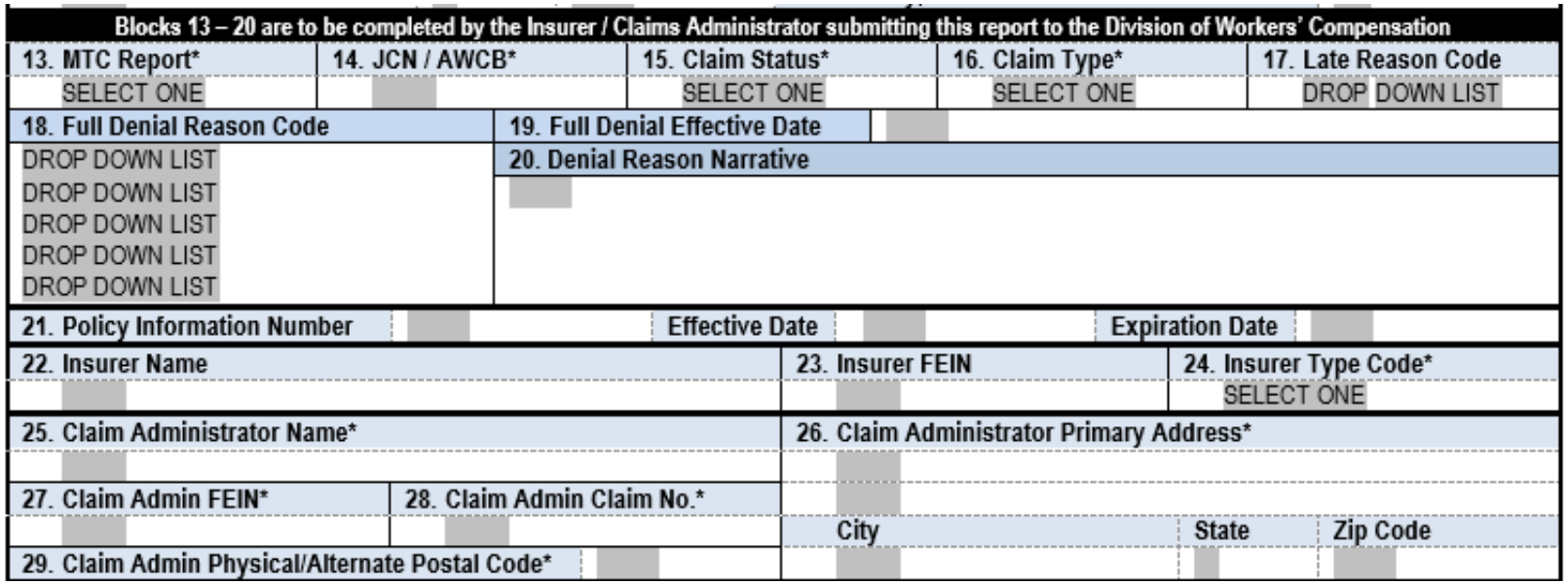
1. Employer Name – The name of your organization
2. Industry (NAICS) Code – School District: 611110
3. Employer Contact Name and Telephone – The name of the primary WC contact at your entity
4. NO NEED TO COMPLETE
5. NO NEED TO COMPLETE
6. Employer Mailing Address – The mailing address of your organization
7. Employer Physical Address- The physical (street) address of your organization

# What Information Does the WC Insurance Carrier Need?




8. Employee Name, Last, First, Middle, Suffix – Provide this information about the injured employee
9. Employee Mailing Address - Provide the injured employee's mailing address
10. Date of Birth – Provide the injured employee's date of birth
11. Date of Death – If the workplace injury resulted in the employee's death, what was that date
12. Employee ID Type & Number – ID Type refers to a Social Security Card, Passport, Green Card Number, or Employment Visa. Number refers to the corresponding number for the ID Type. This will typically be the injured employee's social security number.

# What Information Does the WC Insurance Carrier Need?



| Blocks 13 – 20 are to be completed by the Insurer / Claims Administrator submitting this report to the Division of Workers' Compensation | | | | |
|---|---|---|---|---|
| 13. MTC Report* | 14. JCN / AWCB* | 15. Claim Status* | 16. Claim Type* | 17. Late Reason Code |
| SELECT ONE | | SELECT ONE | SELECT ONE | DROP DOWN LIST |

| 18. Full Denial Reason Code | 19. Full Denial Effective Date | |
|---|---|---|
| DROP DOWN LIST<br>DROP DOWN LIST<br>DROP DOWN LIST<br>DROP DOWN LIST<br>DROP DOWN LIST | 20. Denial Reason Narrative | |

| 21. Policy Information Number | Effective Date | Expiration Date |
|---|---|---|

| 22. Insurer Name | 23. Insurer FEIN | 24. Insurer Type Code* |
|---|---|---|
| | | SELECT ONE |

| 25. Claim Administrator Name* | 26. Claim Administrator Primary Address* | | |
|---|---|---|---|
| | | | |
| 27. Claim Admin FEIN* / 28. Claim Admin Claim No.* | | | |
| | City | State | Zip Code |
| 29. Claim Admin Physical/Alternate Postal Code* | | | |

Items 13 – 29 will be completed by the workers' compensation carrier. You may leave these blank!

# What Information Does the WC Insurance Carrier Need?

| 30. Insured Name | 31. Insured FEIN | 32. Insured Type Code* |
|---|---|---|
| | | SELECT ONE |

| 33. Employment Status* | 34. Days Worked / Week |
|---|---|
| SELECT ONE | |

30. Insured Name – Enter the name of your organization

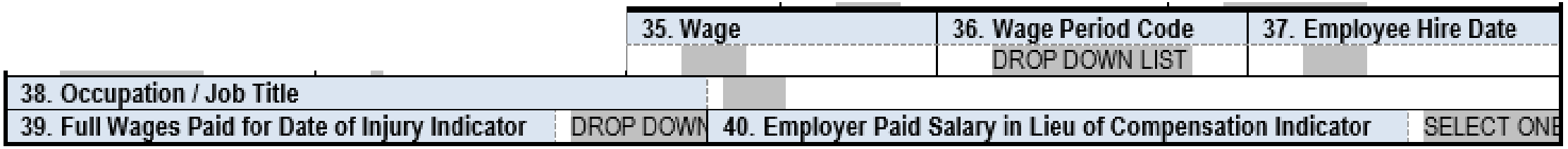
31. NO NEED TO COMPLETE

32. NO NEED TO COMPLETE

33. Employment Status – Regular/Full-time, Part-time, Volunteer Worker, Seasonal Worker, Apprenticeship Full-time, Apprenticeship Part-time, or Other.

34. Days Worked/Weeks – Enter the injured employee's regular work day (example: Monday – Friday)

# What Information Does the WC Insurance Carrier Need?




35. Wage – Enter the employee's regular wage amount. This may be the hourly, daily, weekly, bi-weekly, monthly, or annual wage/salary

36. Wage Period Code – Indicate the wage period for the amount provided in #35

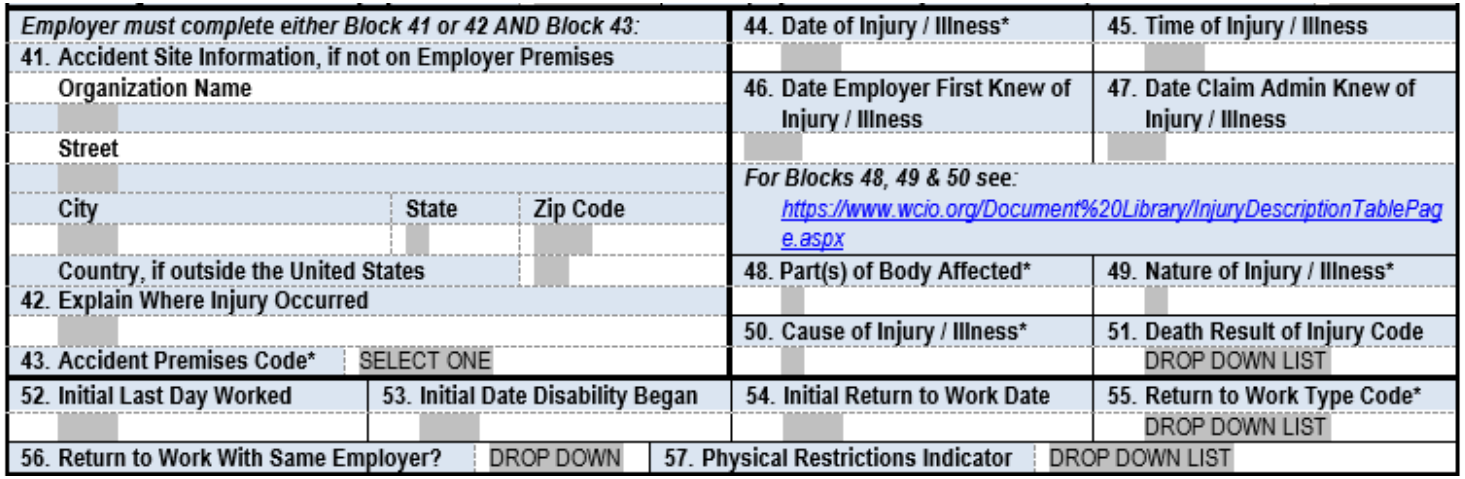
37. Employee Hire Date – Enter the most recent date of hire for the employee

38. Occupation Job/Title – Enter the injured employee's job title

39. Full Wages Paid for Date of Injury Indicator – Indicate Yes or No, if the employee was paid their full wages on the date of the injury.

40. Employer Paid Salary in Lieu of Compensation Indicator – No Need to Complete

# What Information Does the WC Insurance Carrier Need?



| *Employer must complete either Block 41 or 42 AND Block 43:* | | | 44. Date of Injury / Illness* | 45. Time of Injury / Illness |
|---|---|---|---|---|
| 41. Accident Site Information, if not on Employer Premises | | | | |
| Organization Name | | | 46. Date Employer First Knew of Injury / Illness | 47. Date Claim Admin Knew of Injury / Illness |
| Street | | | | |
| City | State | Zip Code | *For Blocks 48, 49 & 50 see:* https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage.aspx | |
| Country, if outside the United States | | | 48. Part(s) of Body Affected* | 49. Nature of Injury / Illness* |
| 42. Explain Where Injury Occurred | | | | |
| | | | 50. Cause of Injury / Illness* | 51. Death Result of Injury Code |
| 43. Accident Premises Code* | SELECT ONE | | | DROP DOWN LIST |
| 52. Initial Last Day Worked | 53. Initial Date Disability Began | | 54. Initial Return to Work Date | 55. Return to Work Type Code* |
| | | | | DROP DOWN LIST |
| 56. Return to Work With Same Employer? | DROP DOWN | | 57. Physical Restrictions Indicator | DROP DOWN LIST |

41. Accident Site Information – If the employee was injured outside of the employer premises, provide the name and address of the location where the injury occurred

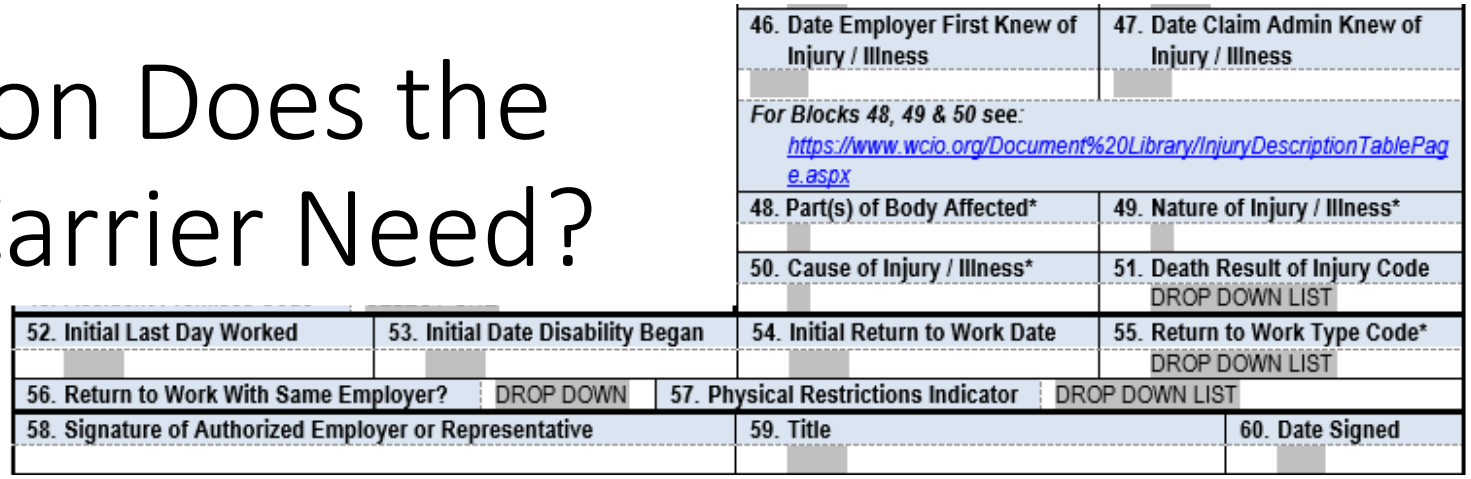
42. Explain Where the Injury Occurred – Describe the location where the injury occurred

43. Accident Premises Code – NO NEED TO COMPLETE

44. Date of Injury/Illness – Enter the date the injury/illness occurred or the probable onset date

45. Time of Injury Illness – Enter the approximate time the injury/illness occurred, if able to determine

# What Information Does the WC Insurance Carrier Need?



| 46. Date Employer First Knew of Injury / Illness | 47. Date Claim Admin Knew of Injury / Illness |
|---|---|
| | |
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| 48. Part(s) of Body Affected* | 49. Nature of Injury / Illness* |
| | |
| 50. Cause of Injury / Illness* | 51. Death Result of Injury Code |
| | DROP DOWN LIST |

| 52. Initial Last Day Worked | 53. Initial Date Disability Began | 54. Initial Return to Work Date | 55. Return to Work Type Code* |
|---|---|---|---|
| | | | DROP DOWN LIST |

| 56. Return to Work With Same Employer? | DROP DOWN | 57. Physical Restrictions Indicator | DROP DOWN LIST |
|---|---|---|---|

| 58. Signature of Authorized Employer or Representative | 59. Title | 60. Date Signed |
|---|---|---|
| | | |

46. Date Employer First Knew of Injury/Illness – Enter the date your organization became aware of the employee's injury or illness

47. Date Claims Admin Knew of Injury/Illness – Enter the date the employer representative responsible for completing and submitting the Report of Injury became aware of the injury.

48. – 57. NO NEED TO COMPLETE

58. Signature of Authorized Employer or Representative – Signature of individual completing this form on behalf of the organization

59. Title – Job title of individual signing #58

60. Date Signed – Enter the date #58 was signed

# What Happens Once a Claim is Reported


As soon as a Report of Injury is received, the claims adjusters review the claim to determine if it is covered.

- If the claim is NOT covered:
  - The adjuster will send the employee a denial notice.
  - Reasons a claim may not be covered include no injury (incident only), late reporting, the injury did not occur in the scope and course of work, or the injury is not unusual or extortionary in nature.
  - The denial notice can be used by the employee to submit to their health insurance company to prove the injury is not covered by workers' compensation.

# What Happens Once a Claim is Reported (cont.)

If the claim results in medical expenses the adjuster will contact both the employee and a designated employer representative (or supervisor).

- The employee will be sent a letter which includes their claim number and the name and contact information for the adjuster working on their claim.
  - This letter will include a medical release, provider list, and a written statement for the employee to complete and return.
  - If the requested information is not submitted, benefits may be denied.
- If the claim results in time away from work, the adjuster will contact the employer and request:
  - The employee's rate of pay, including employer contributions to any pension plan
  - Information about the employee's job duties
  - Other information needed to process the claim

# Other Information the Claims Adjuster will Request from the Employer

- *Who is the employee's immediate supervisor?* If the adjuster feels they need to get clarifying information, they may contact the immediate supervisor.
- *Does the employee have any military experience?* This helps the adjuster identify if there may be any prior injuries that need to be investigated further.
- *Does the employee have any follow up care as a result of the injury?* This helps the adjuster understand the extent of the injury in order to "reserve" the appropriate amount of funds for the claim.
- *Do you have any reason to doubt the validity of the injury?* If the employer has concerns about the potential validity of the claim, the claims adjuster needs to be made aware so they can investigate.
- *Does the employee have any pre-existing health issues that you're aware of?* This information provides insight into whether the recovery time could be impacted by a pre-existing condition.
- *Questions about the employee's job performance.* Poor job performance has been tied to more costly workers' compensation claims.

# Other Employer Responsibilities

- Please respond promptly to adjuster calls or emails. This allows the adjuster to help the injured employee faster.
- Remain in contact with the injured employee to let them know that their well-being and return to work are important to the entity.
- If the employee misses work due to their injury, determine if they may be eligible for leave under FMLA/AFLA. If so, FMLA/AFLA should run concurrently with workers' compensation
- Discuss with the employee, claims adjuster, and possibly the employee's medical provider about the estimated timeline for the employee's return to work and any necessary accommodations.


Resources for APEI Members:

Jessica Garrett, Workers' Compensation Claims Manager: 907-523-9453

Buffy Blais, Workers' Compensation Claims Adjuster: 907-523-9450

Employer's Guide to the Workers' Compensation Act:
https://labor.alaska.gov/wc/employer_guide_to_wc_act.pdf