

## 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.

O. Box 115512, Juneau AK 99811-5		EE: All questions wit	h an asterisk (*) must be	e complete	d	
. Employee Name Last*		First*		iddle		Suffix
. Mailing Address & Telephor	ne Number*		3. Date of Birth*		4. Date	of Death
			5. Social Security N	umber*	6. Gend	er Code
City*	Stat	e* Zip Code*	7 Marital Status	M-Ma	j	☐ M ☐ S-Separated
Country, if outside the Unit	ed States	Telephone No.	7. markar otatuo	U-Unr		K-Unknown
			8. Number of Depen			
Date of Injury / Illness*	10. Time	of Injury / Illness	11. Did Injury / Illne	ss Occur o	n Employer	's Premises?
2. Explain where injury / illne	ss occurred		13. Employer Name			
4. Describe Nature of Injury /	Illness* (i.e.,	sprain, laceration, etc.	15. Describe Part of	f Body Affe	cted*	
6. Describe How the Injury / I	Illness Happe	ned				
9. List Any Machine/Substan			18. Mechanical G 20. If Machine Wi	nat Part?		
9. List Any Machine/Substan				nat Part?		ded? DROP
9. List Any Machine/Substan 1. Witness Name	ce/Object Ca	ising Injury / Illness		witness	s Business	
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List Any Machine/Substan     Witness Name     Attending Physician Name     Initial Treatment*	ce/Object Car	ising Injury / Illness	20. If Machine Wi	witness  Contact Ir	s Business nformation	Phone Number
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## 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

ALASKA DEPARTMENT OF LABOR & 1 Division of Workers' Compensation P.O. Box 115512, Juneau AK 99811-551	2	TO	DIVISION	OF OCCUPATION OF WORKERS' C			
	EMPLOYE	R: All questions with	h an asterisk (	) must be completed			
1. Employer Name*				y (NAICS) Code Requir			
3. Employer Contact Name	& Telephone		Oce III	4. FEIN*	all to so will do to	5. UI Number	
o. Employer contact italic	a reconsis						
6. Employer Mailing Addre	ss*		7. Employ	er Physical Address			
City	State	Zip Code	City		State	Zip Code	
- Ony	State	Zip Code	- Ony		Otate	Zip code	
Country, if outside the Ur	nited States		Country,	if outside the United S	tates		
B. Employee Name, Last			First	Middle	)	Suffix	
9. Employee Mailing Addre			10. Date of	District	11. Date o	4D	
Employee Mailing Addre	ISS"		10. Date of	Birui.	11. Date o	r Death	
City	State	Zip Code	12. Employ SELECT	ee ID Type & Number*			
City	State	Zip Code		, if outside the United	States		
Blocks 13 – 20 are to	be completed by the la	surer / Claims Adminis		ng this report to the Divisi		s' Compensation	
13. MTC Report*	14. JCN / AWCB*	15. Claim S	Status*	16. Claim Type*		Late Reason Code	
SELECT ONE		SELECT		SELECT ONE		DROP DOWN LIST	
18. Full Denial Reason Code		Full Denial Effective					
DROP DOWN LIST	20.	Denial Reason Narra	ative				
DROP DOWN LIST DROP DOWN LIST							
DROP DOWN LIST							
DROP DOWN LIST							
21. Policy Information Numl	ber	Effective	Date	Expi	ration Date		
22. Insurer Name			23. Insurer			r Type Code*	
					SELEC	TONE	
25. Claim Administrator Nar	ne*		26. Claim A	Administrator Primary I	Address*		
27. Claim Admin FEIN*	28. Claim Ac	lmin Claim No.*	City		State	Zip Code	
29. Claim Admin Physical/A	Iternate Postal Code	•	City		otate	Zip code	
30. Insured Name			31. Insured	FEIN	32. Insure	d Type Code*	
				······		T ONE	
33. Employment Status*	34. Days Worked /	Week 35. Wage		36. Wage Period Co	ode 37	Employee Hire Date	
SELECT ONE				DROP DOWN LI	ST	***************************************	
38. Occupation / Job Title							
39. Full Wages Paid for Date				d Salary in Lieu of Com			
Employer must complete ell 41. Accident Site Informatio			44. Date of	Injury / Illness*	45. Time (	of Injury / Illness	
Organization Name	n, if not on Employe	r Premises	46 Data E	mployer First Knew of	47 Date (	Claim Admin Knew of	
Organization Hame			Injury /			/ Illness	
Street					y		
				48, 49 & 50 see:			
City	State	Zip Code	https://v e.aspx	www.wcio.org/Document	%20Library/Ir	njuryDescriptionTablePa	
Country, if outside the U	Inited States		48. Part(s)	of Body Affected*	49. Nature	of Injury / Illness*	
12. Explain Where Injury Oc	curred						
43 Applicant Draminas Code	• OFFICE ONE		50. Cause	of Injury / Illness*		Result of Injury Code	
<ol> <li>Accident Premises Code</li> <li>Initial Last Day Worked</li> </ol>		ate Disability Began	E4 toitial f	Deturn to West Date		DOWN LIST to Work Type Code*	
oz. muai Last Day Worked	53. Initial Da	ne visability Began	54. Initial F	Return to Work Date		DOWN LIST	
56. Return to Work With Sar	me Employer?	ROP DOWN 57. F	Physical Restri	ctions Indicator DR	OP DOWN LI		
58. Signature of Authorized			59. Title	Dit.	J. DOMITE	60. Date Signed	
			30. Tue			out organica	

## 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!

ALASKA DEPARTMENT OF LABOR & WORKF Division of Workers' Compensation P.O. Box 115512, Juneau AK 99811-5512		i	DIV	'ISI	ON OF WOR	KE	RS' CC				NESS
	EMPLOYER	: All questions with	an a	aste	isk (*) must be o	omp	leted				
1. Employer Name*			2.	Inc	lustry (NAICS) C	ode	Require	d on New C	laims'	•	
				Se	e http://www.cens	sus.g	ov/cgi-bir	n/sssd/naics	/naics	rch	
3. Employer Contact Name & Telephone						4.	FEIN*		5.	UI Nun	nber
						Ī					
6. Employer Mailing Address*			7.	En	ployer Physical	Add	ress				
			[								
City	State	Zip Code	[	City	'			State	Zi	p Code	е
			i								
Country, if outside the United States				Cou	ntry, if outside t	he U	nited Sta	ates			
				-							

- 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

8. Employee Name, Last			First	Middle	Suffix	
9. Employee Mailing Address	*		10. Date of Birth*	1	1. Date of Death	
			12. Employee ID	Type & Number*		
City	State	Zip Code	SELECT ONE			
			Country, if ou	itside the United Stat	es	

- 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.

Blocks 13 – 20 are to b	e completed by	the Insurer / Cla	ims Administrator su	bmitting t	this report to the Division of	Workers' Compensation		
13. MTC Report*	14. JCN / AWC	B*	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 Deni	ial Effective Date					
DROP DOWN LIST	20. Denial Re	eason Narrative						
DROP DOWN LIST								
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DROP DOWN LIST								
21. Policy Information Numb	er		Effective Date		Expiration	Date		
22. Insurer Name			23. li	nsurer Fl	EIN 24.	Insurer Type Code*		
						SELECT ONE		
25. Claim Administrator Nam	ie*		26. 0	26. Claim Administrator Primary Address*				
27. Claim Admin FEIN*	28. Clair	n Admin Clain	n No.*					
						-t-   7!- 0- t-		
				ity	St	ate Zip Code		

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

30. Insured Name 31. In	nsured FEIN	32. Insured Type Code*
33. Employment Status* 34. Days Worked / Week SELECT ONE		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)

	35. Wage	36. Wage Period Code	37. Employee Hire Date
		DRÖP DOWN LIST	
		DITOI DOWN LIOT	
38. Occupation / Job Title			
39. Full Wages Paid for Date of Injury Indicator	DROP DOWN 40. Employ	er Paid Salary in Lieu of Compensat	ion Indicator   SELECT ONE

- 35. Wage Enter the employee's regular wage amount. This may be the hourly, daily, weekly, biweekly, monthly, or annual wage/salary
- 36. Wage Period Code Indicate the <u>wage period</u> 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

Employer must complete either Bi	mployer must complete either Block 41 or 42 AND Block 43:				45. Time of Injury / Illness		
41. Accident Site Information, if not on Employer Premises				44. Date of Injury / Illness*			
Organization Name			46. Date Employer First Knew of	47. Date Claim Admin Knew of			
				Injury / Illness	Injury / Illness		
Street							
			For Blocks 48, 49 & 50 see:				
City	State	Zip Code		https://www.wcio.org/Document%20Library/InjuryDescriptionTable/			
				<u>e.aspx</u>			
Country, if outside the United				48. Part(s) of Body Affected*	49. Nature of Injury / Illness*		
42. Explain Where Injury Occurred	l						
				50. Cause of Injury / Illness*	51. Death Result of Injury Code		
43. Accident Premises Code*	BELECT ONE				DROP DOWN LIST		
52. Initial Last Day Worked	53. Initial Da	ite Disability B	egan	54. Initial Return to Work Date	55. Return to Work Type Code*		
					DROP DOWN LIST		
56. Return to Work With Same Em	ployer? D	ROP DOWN	57. Ph	ysical Restrictions Indicator DRC	P 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 WC Insurance Car

on Does	the	-	46. Date Employer First Knew of Injury / Illness Injury / Illness  For Blocks 48, 49 & 50 see:  https://www.wcio.org/Document%20Library/InjuryDescriptionTablePage asox					
arrier Need?			48. Part(s) of Body Affected* 49. Nature of Injury / Illness*  50. Cause of Injury / Illness* 51. Death Result of Injury Co					
52. Initial Last Day Worked	53. Initial Date Disability Began	ın	54. Initial Return to Work Date		to Work Type Code*			
56. Return to Work With Same Em	ployer? DROP DOWN 57	. Phy	sical Restrictions Indicator DRO	P DOWN LIS	T			
58. Signature of Authorized Employer or Representative			59. Title		60. Date Signed			

46 Data Employer First Many of 47 Data Claim Admin Many of

- 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