

We Need Your Help!**To Our Alaska Policyholders:**

Thank you for selecting Republic Indemnity Company as your workers' compensation insurance carrier. Our goal is to provide you with courteous and efficient claim service whenever you report an accident, injury, or disability.

To facilitate claims handling in the State of Alaska, Northern Adjusters, Inc., has been appointed as Republic's claim service representative. Your cooperation and close working relationship with Northern Adjusters, Inc., is *vital* to this process. In the event you have any questions, please feel free to contact Susan Daniels at the following address:

Northern Adjusters, Inc.
1401 Rudakof Circle
Anchorage, AK 99508
(907) 868-3999 (Phone)
(907) 868-3866 (Fax)

In order to most effectively serve your workers' compensation claim handling needs, we ask that you carefully read and comply with the following:

- Review and become familiar with all of the material contained in this folder.
- In the event of an employee accident, injury, or disability, provide the employee with **Form 07-6101 Report of Occupational Injury or Illness**. Once the employee and the employer sections have been completed, forward the original to Northern Adjusters, Inc., in the envelope provided, provide one copy to the employee, and keep a copy for your records.
- In the event of serious injury, call Northern Adjusters immediately at (907) 868-3999. Report it by telephone and follow-up with **Form 07-6101**.
- Be sure to report **ALL** claims, no matter how minor.

NOTICE TO OUR ALASKA POLICYHOLDERS: Copies of *Form 07-6101 Report of Occupational Injury or Illness* are also available for download at our website (www.republicindemnity.com) under "Claims Forms & Posting Notices."

Remember, the degree to which we are able to service your claims depends in large part on how quickly and completely you report employee accidents, injuries and/or illnesses.

In order for the workers' compensation program to work effectively, communication between you -- the employer -- and Northern Adjusters, Inc. -- Republic's claims handling representative -- must be timely and mutually supportive.

INTRODUCTION TO REPUBLIC INDEMNITY'S CLAIMS DEPARTMENT

Thank you for selecting Republic Indemnity Company as your workers' compensation insurance carrier. Please familiarize yourself with the contents of this claims kit and your mandatory posting and reporting requirements.

To assist you in obtaining information timely, the following is a list of the phone numbers, fax numbers and addresses of our California and Arizona offices. Should you be located in a state administered by a Third Party Administrator, we have also included their phone numbers, fax numbers, and addresses.

California:

Claims Mailing Address: Republic Indemnity, P.O. Box 4275, Woodland Hills, California 91365-4275
 Phone (800) 821-4520, option 1 · Fax (818) 789-7286 · eMail rclaims@ri-net.com

Greater Bay Area:

Phone (415) 981-3200 · Fax (415) 954-1177

Los Angeles / Tri-County / Orange County / San Joaquin Valley:

Phone (818) 990-9860 · Fax (818) 789-7286

San Diego / San Bernardino / Riverside / Imperial County:

Phone (858) 292-7002 · Fax (858) 467-7815

Arizona / Colorado / Kansas / Missouri:

Claims Mailing Address: Republic Indemnity, P.O. Box 4275, Woodland Hills, California 91365-4275
 Phone (602) 912-9505 · Fax (602) 912-9509

Third Party Administrators:

Northern Adjusters, Inc. 1401 Rudakof Circle Anchorage, Alaska 99508 Phone (907) 868-3999 · Fax (907) 868-3866	The Integrion Group 5201 Balloon Fiesta Parkway NE P.O. Box 27815 Albuquerque, New Mexico 87125 Phone (505) 293-6600 · Fax (505) 293-6400
Intermountain Claims, Inc. 170 South Cole P.O. Box 4367 Boise, Idaho 83711 Phone (208) 323-7571 · Fax (208) 375-8905	Intermountain Claims, Inc. P.O. Box 23547 Portland, Oregon 97281-3547 Phone (503) 626-6966 · Fax (503) 626-7105
Intermountain Claims, Inc. P.O. Box 4546 Missoula, Montana 59806-4546 Phone (406) 542-8869 · Fax (406) 542-8870	Anchor Claims Management P.O. Box 819045 Dallas, Texas 75381-9045 Phone (800) 275-3193 · Fax (800) 275-3194
Nevada Alternative Solutions, Inc. 9506 W. Flamingo Road, Suite 102 Las Vegas, Nevada 89147 Phone (702) 796-1333 · Fax (702) 796-1330	Intermountain Claims, Inc. 1543 East 3300 South Salt Lake City, Utah 84106 Phone (801) 466-7993 · Fax (801) 466-1749

You and Republic Indemnity – Partners in Workers' Compensation

It's the Law:

- Failure to file the Report of Occupational Injury or Illness (Form 07-6101) within ten days after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you, may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker.
- Immediate reporting will help minimize the potential for fines and legal action.

Our Part -- Experienced Claims Professionals dedicated to handling your claims.

Your Part -- Promptly reporting claims; choose the method that works best for you:

- **Online** : www.republicindemnity.com
- **Fax** : 907-868-3866
- **eMail** : wcnewclaim@nadj.com
- **Phone** : 888-336-7569 (24 hours a day)
- **Mail** : Northern Adjusters, Inc., 1401 Rudakof Circle, Anchorage, AK 99508

NOTICE TO OUR ALASKA POLICYHOLDERS: Copies of *Form 07-6101 Report of Occupational Injury or Illness* are also available for download at our website (www.republicindemnity.com) under "Claims Forms & Posting Notices."

The Benefits of Prompt Reporting

Immediate Medical Care for Your Injured Workers:

- Early, appropriate medical care speeds recovery;
- Faster recovery means more motivation to return to work;
- Faster recovery reduces claims costs;
- Faster recovery minimizes loss of productivity for your business.

Republic Can More Quickly Process Claims, Address Your Employee's Needs, and Earn Their Trust:

- The Claims Professionals at Northern Adjusters, Inc., Republic's claim service representative in Alaska, promptly contact injured workers to answer their questions and encourage phone and eMail contact about medical care, lost income and future needs—facilitating the prompt payment of benefits when due.

Republic Can Gather Evidence to Defend Litigated Claims:

- The Claims Professionals at Northern Adjusters, Inc., can quickly collect vital information to more effectively defend your claims.
- Licensed Private Investigators are able to gather additional information for complex or questionable claims before evidence disappears or memories fade.



EMPLOYER SUPPLY REQUEST - ALASKA

Employer:	
Policy No:	Phone No:
Address:	
City, State, Zip:	
Attention:	
eMail:	

QUANTITY	FORM NO.	DESCRIPTION
CLAIM FORMS ("IF A WORK INJURY OCCURS...")		
	Form 07-6101	Employer Report of Occupational Injury or Illness
	Form 07-6100	Employee Report of Occupational Injury or Illness
	170-367	Authorization for Medical Treatment
	Self-Addressed Envelopes	Northern Adjusters, Inc.
INFORMATION FOR YOUR EMPLOYEES		
	170-405	Fraud Payroll Stuffers
WORKERS' COMPENSATION POSTING NOTICE		
	Form 07-6120	Employer's Notice of Insurance
ADDITIONAL SUPPLIES		

NOTICE TO OUR ALASKA POLICYHOLDERS: Copies of *Form 07-6100 Employee Report of Occupational Injury or Illness* and *Form 07-6101 Employer Report of Occupational Injury or Illness* are also available for download at our website (www.republicindemnity.com) under "Claims Forms & Posting Notices."

As a reminder, please submit your completed claim form to Northern Adjusters, Inc., via fax (907.868.3866) or eMail (wnewclaim@nadj.com) *within ten days* of every industrial injury or illness.

Please direct your supply request to:

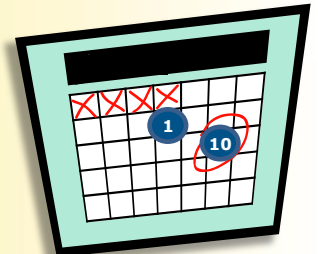
Republic Indemnity
Mail / Supply Department
P.O. Box 4275, Woodland Hills, CA 91365-4275
Fax: (818) 382-1133
eMail: riclaims@ri-net.com

- Should you wish to order additional claim forms or other workers' compensation supplies, please submit your completed supply request form or contact our Mail / Supply Department via eMail (riclaims@ri-net.com) or fax (818.382.1133).
- You also may download claim forms on-line at our website (www.republicindemnity.com).
- For your convenience, we've highlighted Alaska state-mandated forms:
- We've also highlighted additional forms recommended for your injured workers:



CLAIM FORMS ("IF A WORK INJURY OCCURS...")

It is our goal that your employees receive quality medical treatment and return to work in the shortest possible time. In order to achieve this goal, it is imperative that any injury be reported immediately.



- In the event of an employee accident, injury, or disability, provide the employee with **Form 07-6100 Employee Report of Occupational Injury or Illness**.
- Also provide a copy of the **Authorization for Industrial Medical, Surgical or Hospital Aid** to the injured worker *at the time of referral for initial medical care*.
- Once the employee claim form has been completed, forward the original to **Northern Adjusters, Inc.** in the envelope provided, provide one copy to the employee, and keep a copy for your records.
- You are also required to file **Form 07-6101 Employer Report of Occupational Injury or Illness** *within ten days* of every industrial injury or occupational illness. Be sure to report ALL claims, no matter how minor.
- In the event of serious injury, call Northern Adjusters immediately at **907.868.3999**.

As a reminder, you may report new claims on-line at our policyholder website (www.republicindemnity.com); Also via Fax (907.868.3866); eMail (wcnewclaim@nadj.com); Phone (888.336.7569 — 24-hours a day); or U.S. Mail (Northern Adjusters, Inc., 1401 Rudakof Circle, Anchorage, AK 99508).

- Your completed claim form will be submitted electronically via electronic data interchange (EDI) to the Alaska Division of Workers' Compensation by Republic Indemnity.

Employer 07-6101 Claim Form (Form 07-6101; Rev. 2/2017)		Please submit this claim via fax (907.868.3866) or eMail (wcnewclaim@nadj.com) <i>within ten days</i> of every industrial injury or illness.
Employee 07-6100 Claim Form (Form 07-6100; Rev. 4/1/2015)		You are required to provide an injured worker with the 07-6100 Claim Form <i>immediately</i> upon your knowledge of an alleged injury.
Authorization for Medical Treatment (170-367; Rev. 3/2020)		Authorization for Medical Treatment should be provided to an injured worker <i>at the time of referral for initial medical care</i> .
Northern Adjusters, Inc. Self-Addressed Envelopes (Attn: Workers' Compensation)		Our Claims Mailing Address: Northern Adjusters, Inc., 1401 Rudakof Circle, Anchorage, AK 99508.

INFORMATION FOR YOUR EMPLOYEES

Help us put a stop to fraudulent claims by distributing the following notices *to all employees in paycheck envelopes.*

Fraud Payroll Stuffers (170-405; Rev. 5/2013)		We encourage you to insert notices in paycheck envelopes to help heighten awareness that workers' comp fraud is a felony that hurts everyone.
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WORKERS' COMPENSATION POSTING NOTICE

The following state-mandated notice *must be posted in three conspicuous places on the employer's premises.*

Form 07-6120 Alaska Posting Notice (Form 07-6120; Rev. 5/2012)		Please complete the state-mandated Employer's Notice of Insurance and <i>display in three conspicuous places on the employer's premises.</i>
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Thank you for selecting Republic Indemnity Company as your workers' compensation insurance carrier.

Should you wish to submit a completed claim form, medical report, or other information, our claims fax number is 907.868.3866 or eMail us at wcnewclaim@nadj.com.

Our Claims Mailing Address: Northern Adjusters, Inc., 1401 Rudakof Circle, Anchorage, AK 99508. Phone: 907.868.3999.

**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*					7. Employer Physical Address								
City			State		Zip Code			Country, if outside the United States					
City			State		Zip Code			Country, if outside the United States					
8. Employee Name, Last					First		Middle		Suffix				
9. Employee Mailing Address*					10. Date of Birth*			11. Date of Death					
City			State		Zip Code			Country, if outside the United States					
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 Republic Indemnity				23. Insurer FEIN			24. Insurer Type Code* I Insurer						
25. Claim Administrator Name* Northern Adjusters, Inc.				26. Claim Administrator Primary Address* 1401 Rudakof Circle									
27. Claim Admin FEIN*		28. Claim Admin Claim No.*			City		State		Zip Code				
29. Claim Admin Physical/Alternate Postal Code*				Anchorage		AK		99508					
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:					44. Date of Injury / Illness*			45. Time of Injury / Illness					
41. Accident Site Information, if not on Employer Premises					46. Date Employer First Knew of Injury / Illness			47. Date Claim Admin Knew of Injury / Illness					
Organization Name					City			State			Zip Code		
Street													
Country, if outside the United States													
42. Explain Where Injury Occurred					48. Part(s) of Body Affected*			49. Nature of Injury / Illness*					
43. Accident Premises Code* SELECT ONE		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					

Instructions for

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

Employer: This form must be completed and sent immediately, and in no case later than **ten (10) days** after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you. You have the option of completing this form electronically or by hand prior to sending the completed to your Insurer/Claims Administrator (Adjuster).

The form should be submitted electronically via electronic data interchange (EDI). If you or your insurer is not registered and approved to submit reports electronically, mail this form (07-6101) and form 07-6100 to the Division of Workers' Compensation, P.O. Box 115512, Juneau, AK 99811-5512. Make sure and keep a copy for your records.

Failure to file this report within the required time may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker.

AS 23.30.070

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

AS 23.30.107

OSHA REQUIREMENTS

Report industrial deaths and accidents to the Division of Labor Standards and Safety.

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

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

"Injury" means accidental injury or death arising out of in the course of employment and an occupational disease, illness, or infection which arises naturally out of the employment or which naturally or unavoidably results from an accidental injury.

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

**Alaska Division of Worker's
Compensation Offices:**

Anchorage: 3301 Eagle Street, #304
Anchorage, AK 99503-4149
(907) 269-4980

Fairbanks: 675 Seventh Avenue, Station K
Fairbanks, AK 99701-4531
(907) 451-2889

Juneau: 1111 West 8th Street, #305
PO Box 115512
Juneau, AK 99811-5512
(907) 465-2790

**Alaska Division of Labor Standards
and Safety Offices:**

3301 Eagle Street, #305
Anchorage, AK 99503-4149
(907) 269-4940 or
(800) 770-4940

1111 West 8th Street, #304
PO Box 111149
Juneau, AK 99811-1149
(907) 465-4855

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	
City* State* Zip Code*		5. Social Security Number*	6. Gender Code <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> U	
Country, if outside the United States Telephone No.		7. Marital Status <input type="checkbox"/> M-Married <input type="checkbox"/> S-Separated <input type="checkbox"/> U-Unmarried <input type="checkbox"/> K-Unknown	8. Number of Dependents	
9. Date of Injury / Illness*	10. Time of Injury / Illness	11. Did Injury / Illness Occur on Employer's Premises? <input type="checkbox"/> Y-Yes <input type="checkbox"/> 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* <input type="checkbox"/> 0-No Medical Treatment <input type="checkbox"/> 1-Minor On-site Remedies by Employer Medical Staff <input type="checkbox"/> 2-Minor Clinic/Hospital Remedies and Diagnostic Testing <input type="checkbox"/> 3-Emergency Evaluation, Diagnostic Testing, and Medical Procedures <input type="checkbox"/> 4-Hospitalization Greater than 24 Hours <input type="checkbox"/> 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:				27. Date Signed
26. If Employee Unavailable for Signature, Explain Circumstances in this Space				

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).

Instructions for EMPLOYEE REPORT OF OCCUPATIONAL INJURY OR ILLNESS TO EMPLOYER

TO THE EMPLOYEE

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

The employer will notify their insurer, their claims administrator, and the Division of Workers' Compensation of your injury.

After obtaining medical treatment, tell your health care provider's office to submit the required "Physician's Report" (8 AAC 45.086) to your employer.

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

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

www.labor.state.ak.us/wc

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

TO THE EMPLOYER

The information on this form (07-6100) and the information on form 07-6101 must be submitted to the Division of Workers' Compensation immediately and in no case later than **ten (10) days** after you have knowledge that your employee has been injured, or claims to have been injured or become ill while working for you.

Failure to file these reports within the required time may subject you and/or your insurer to a penalty equal to 20 percent of the amount of compensation due to the injured worker.

Alaska Division of Worker's Compensation Offices

Anchorage:
3301 Eagle Street, Suite 304
Anchorage, AK 99503-4149
(907) 269-4980

Fairbanks:
675 Seventh Avenue, Station K
Fairbanks, AK 99701-4531
(907) 451-2889

Juneau:
1111 W 8th St, Rm 305, Juneau AK 99801
PO Box 115512, Juneau AK 99811-5512
(907) 465-2790



AUTHORIZATION FOR INDUSTRIAL MEDICAL, SURGICAL OR HOSPITAL AID

Employer:	Policy No:
Date of Injury:	By:
To:	, M.D.
Address:	
Please render necessary medical service to:	
and immediately forward "DOCTOR'S FIRST REPORT OF WORK INJURY," together with this authorization, to the appropriate servicing office.	

California:

Claims Mailing Address: Republic Indemnity, P.O. Box 4275, Woodland Hills, California 91365-4275
Phone (800) 821-4520, option 1 · Fax (818) 789-7286 · eMail riclaims@ri-net.com

Greater Bay Area:

Phone (415) 981-3200 · Fax (415) 954-1177

Los Angeles / Tri-County / Orange County / San Joaquin Valley:

Phone (818) 990-9860 · Fax (818) 789-7286

San Diego / San Bernardino / Riverside / Imperial County:

Phone (858) 292-7002 · Fax (858) 467-7815

Arizona / Colorado / Kansas / Missouri:

Claims Mailing Address: Republic Indemnity, P.O. Box 4275, Woodland Hills, California 91365-4275
Phone (602) 912-9505 · Fax (602) 912-9509

Third Party Administrators:

Northern Adjusters, Inc. 1401 Rudakof Circle Anchorage, Alaska 99508 Phone (907) 868-3999 · Fax (907) 868-3866	The Integrion Group 5201 Balloon Fiesta Parkway NE P.O. Box 27815 Albuquerque, New Mexico 87125 Phone (505) 293-6600 · Fax (505) 293-6400
Intermountain Claims, Inc. 170 South Cole P.O. Box 4367 Boise, Idaho 83711 Phone (208) 323-7571 · Fax (208) 375-8905	Intermountain Claims, Inc. P.O. Box 23547 Portland, Oregon 97281-3547 Phone (503) 626-6966 · Fax (503) 626-7105
Intermountain Claims, Inc. P.O. Box 4546 Missoula, Montana 59806-4546 Phone (406) 542-8869 · Fax (406) 542-8870	Anchor Claims Management P.O. Box 819045 Dallas, Texas 75381-9045 Phone (800) 275-3193 · Fax (800) 275-3194
Nevada Alternative Solutions, Inc. 9506 W. Flamingo Road, Suite 102 Las Vegas, Nevada 89147 Phone (702) 796-1333 · Fax (702) 796-1330	Intermountain Claims, Inc. 1543 East 3300 South Salt Lake City, Utah 84106 Phone (801) 466-7993 · Fax (801) 466-1749

EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

REPUBLIC INDEMNITY COMPANY

Insurer

P.O. BOX 4275

Street and Number

WOODLAND HILLS

City

CALIFORNIA

State

91365

Zip Code

For the period from _____ Through _____

NORTHERN ADJUSTERS, INC.

Adjusting Company

1401 RUDAKOF CIRCLE

Street and Number

ANCHORAGE

City

ALASKA

State

99508

Zip Code

907-868-3999

Telephone

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act

Employer

By

Title

Witness

Witness

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the "Report of Occupational Injury or Illness" form from your employer for this purpose

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Suite 304
Anchorage AK 99503
(907) 269-4980

FAIRBANKS
675 7th Ave
Station K
Fairbanks AK 99701-4531
(907) 451-2889

JUNEAU
PO Box 115512
1111 W 8th St Rm 305
Juneau AK 99811-5512
(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.



HELP US HELP YOU

Workers' compensation fraud drives your premiums up, up, up, reduces potential dividends, creates mountains of paperwork, and reduces actual benefits available to legitimately injured workers. **IT'S A CRIME.**

Help us put a stop to fraudulent claims.

We are anxious to send you a supply of the notice illustrated below free of charge. If you will insert the notices in your employees' paycheck envelopes, it will help heighten awareness that workers' compensation fraud is a felony that hurts everyone.

TO ORDER, SIMPLY WRITE YOUR COMPANY NAME AND ADDRESS BELOW, INDICATING THE QUANTITY DESIRED, AND RETURN TO US. WE RECOMMEND YOU ORDER A SUFFICIENT SUPPLY TO COVER ONE PAYROLL PERIOD.

A person who willfully makes a false or misleading statement or representation for the purpose of obtaining or denying a benefit or payment under this chapter is guilty of theft by deception as defined in AS 11.46.180 and is punishable as provided in AS 11.46.120-11.46.150.

Examples of fraud include filing a claim for a non-existing injury, for a non-work related injury, or helping a co-worker file a false claim.

False claims cause your employer's insurance costs to go up, and may force jobs to be eliminated.

It hurts everyone – Don't do it.

(AS 23.30.250)

Quantity:
Employer:
Address:
City, State, Zip:
Attention:

Please direct your request to:

Republic Indemnity
Mail / Supply Department
P.O. Box 4275
Woodland Hills, CA 91365-4275
Fax: (818) 382-1133
eMail: riclaims@ri-net.com

Privacy Notice and Notice of Information Practices

Republic Indemnity Company of America and Republic Indemnity Company of California ("Republic Indemnity") respect your right to privacy.

We want you to know about our procedures for protecting your privacy and your rights and responsibilities regarding information we receive about you. We want you to understand how we gather information about you, how we protect it, and how you can help ensure its accuracy. Although we may provide this Notice as information to additional persons, the terms of this Notice apply to those individuals who inquire about or obtain insurance from Republic Indemnity primarily for personal, family or household purposes, and certain group insurance plans. We will provide our customers with a copy of the most recent notice of our privacy policy at least annually and more often if we make any changes affecting their rights under our privacy policy. This Notice applies to current and former customers of Republic Indemnity, but does not in any way imply or affect insurance coverage. You can find the online version of this Notice on our web site at www.republicindemnity.com.

Because Republic Indemnity does not share your information outside of permitted exceptions, there is no need for you to take any action under this Notice. If we change our practices in the future, we will advise you and, if applicable, enable you to "opt-out" of certain sharing.

1. What kind of information is collected about you?

We get most of our information about you directly from you, such as your name, address, social security number, income level and certain other financial information, on insurance applications and other forms that you provide to us. While in some cases the information you provide to your insurance representative during the insurance application process gives us all the information we need to evaluate you or your property for insurance, there are instances when we may need additional information or may need to verify information you have given us. In those cases, we may obtain information from outside sources at our own expense.

It is common for an insurance company to ask an independent source to verify and supplement information given on an insurance application. There are many such independent companies, commonly called "consumer reporting agencies, which are in the business of providing independent information to insurance and other financial services companies. We will treat the information we

receive about you from an independent reporting agency in accordance with the terms of this Notice. Upon our receipt of your written request sent to the address set forth in Section 5, we will inform you of the name and address of any agency we have used to prepare a report on you so that you can contact the agency.

Once you have been an insured customer of ours for a period of time, your record may contain information related to our experiences and transactions with you, such as insurance policy coverage, premiums and payment history, and any claims you make under your insurance policy. For example, information collected by a claims representative and any police or fire report will be retained by us. Any information that we collect in connection with an insurance claim will be kept in accordance with this Notice.

Each company within Republic Indemnity may disclose information about you to an affiliate regarding its transactions and experiences with you (such as your payment or claims history). We do not currently share other credit-related information, except as permitted or required by law.

Finally, we do use "cookies" when you interact with our web sites to make that experience easy and meaningful for you. When you visit our web site, our web server sends a cookie to your computer. A cookie is an electronically transmitted file that holds small pieces of information. When you navigate through our web site, your browser "requests" pages for you to view, and that request will include the information stored in the cookie we previously sent to your computer. This process is like an electronic "handshake" between our system and your computer; the information exchanged allows us to recognize your browser.

Cookies are used to collect and store only the following information: the visitor's domain name, the Internet address of the web site from which the visitor linked directly to our web site, the pages of our site that the visitor views and the length of time spent on each page, browser and operating system platform type, and the date and time the visitor access our site.

Cookies, as well as data taken from them, do not identify you personally. They merely recognize your browser. Unless you choose to identify yourself to us, either by responding to a promotional offer, buying a policy, or registering for an online service, you remain anonymous.

Session cookies exist only during an online session with Republic Indemnity. Session cookies allow you to conduct transactions or requests on our web site. Without the session cookie information, we would not be able to complete your web transactions securely. Session cookies help us make sure you are who you say you are after you have logged in. We do not sell this or any other information about you to other web sites, merchants or financial institutions.

2. What do we do with the information about you?

Information about you will be kept in our insurance policy records. We will refer to and use that information for purposes related to issuing and servicing insurance policies and settling claims. Generally, personal information about you in our records will not be disclosed by us to any external organization without your prior authorization. However, we may, as permitted by law, share information about you contained in our files with certain persons or organizations such as:

- your insurance representative,
- persons who represent you in a fiduciary capacity, including your attorney or trustee, or who have a legal interest in your insurance policy,
- adjusters, appraisers, auditors, investigators and attorneys,
- persons or organizations who need the information to perform a business, professional or insurance function for us,
- other insurance companies, agents or consumer reporting agencies as information is needed in connection with any insurance application, policy or claim involving you,
- medical professionals to inform you of a medical condition of which you may not be aware,
- persons or organizations that conduct research, including actuarial or underwriting studies, provided that no individual information may be identified in any research study report,
- persons or organizations that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements,
- our affiliated companies, or
- to a court, state insurance department or other government agency pursuant to a summons, court order, search warrant, subpoena, or as otherwise required by law or regulation.

Except as permitted or required by law, unless we obtain your written consent, we will not use or share any personally identifiable health information about you for any purpose other than underwriting or administration of your insurance policy, claim or account, or in a manner as previously disclosed to you by us when we collected such information.

When your nonpublic personal financial or health information is disclosed by us to third parties for certain purposes described above, we will require them to use your information only for its intended purpose.

3. Who has access to your information?

Republic Indemnity currently incorporates a system of passwords and other appropriate physical, electronic and procedural safeguards to protect against unauthorized access to potentially private information. We will educate our employees about the terms of this Notice and the importance of confidentiality and customer privacy. Employees who gain unauthorized access or who otherwise violate our privacy policy are subject to disciplinary action up to and including termination of employment. We plan to monitor and evaluate our information security program and available security software in light of relevant changes in technology to determine ways to increase protections to the security or integrity of our records and information.

4. How can you review recorded information about you?

Generally, you have the right to review and receive a copy of the recorded personal information about you contained in our files with respect to a particular policy number, except for certain legal and medical documents. You have the further right to request that we correct any of this information. To exercise these rights, you must send to us a notarized request at the address set forth below stating your complete name, address, insurance policy number, daytime phone number, and a copy of your driver's license or other personal identification. If you believe any information is incorrect, we will investigate and correct it if we can substantiate the error. Even if we do not correct the information, you have the right to file with us a written statement of dispute which we will include in any future disclosure for information.



Workers' Compensation Insurance

5. How can you contact us?

If, after reading this, you have any questions about our privacy policy, please write to us at the following address:

REPUBLIC INDEMNITY COMPANY OF AMERICA
REPUBLIC INDEMNITY COMPANY OF CALIFORNIA
P.O. Box 4275
Woodland Hills, CA 91365-4275
Attn: Compliance Office – Privacy

170-045 (3/2020)

TO OUR POLICYHOLDERS

Compliance With U.S. Economic Sanctions Laws

Under various federal laws, the Office of Foreign Assets Control (OFAC), a division of the U.S. Department of Treasury, administers and enforces economic sanctions against certain countries and groups of individuals, such as terrorists and narcotics traffickers. These laws prohibit United States citizens, corporations, and others from engaging in virtually all business transactions with countries, individuals and entities designated on the list of Specially Designated Nationals and Blocked Persons (the SDN list).

Insurance companies are prohibited from paying claims to anyone on the SDN list or to those otherwise subject to U.S. Economic Sanctions Laws. Therefore, Republic Indemnity will screen all workers' compensation claimants against the SDN list before making payments.

If an injured employee's name matches a name on the SDN list, we may need to contact you as the employer to obtain additional information. We will want to verify that the injured employee is not the same person identified on the SDN list and that Republic Indemnity is not otherwise prohibited under U.S. Economic Sanctions Laws from paying the claim.

Republic Indemnity is committed to delivering quality claim service to our policyholders. Prompt payment of claims is dependent on accurate information and legal compliance in obtaining claimant information.

You can access the United States Department of the Treasury website at www.ustreas.gov/offices/enforcement/ofac/ for additional information, or contact your Human Resources Department or legal counsel if you have any questions.

This communication is for informational purposes only. It is not intended to be an exhaustive treatment of the legal issues discussed, nor is it intended to furnish legal advice appropriate to any particular circumstances. This information is not intended to create and does not create an attorney-client relationship, and this information does not constitute an attorney-client communication.