

WORKERS' COMPENSATION AND YOU

INFORMATION FOR INJURED WORKERS

The purpose of this web brochure is to give a brief explanation of some basic information that you should know if you are injured on the job. You should read it carefully to make sure that you know both your rights and your responsibilities. Workers' compensation is a program that requires your employer to provide medical benefits, disability benefits and re-employment benefits if you are injured, or become ill, where the injury or illness is caused by the work you performed for your employer. In cases involving fatalities, dependents may be eligible for death benefits. Should you need additional information after reading this brochure, please contact the Division of Workers' Compensation at (907) 465-2790 in Juneau, (907) 269-4980 in Anchorage or (907) 451-2889 in Fairbanks.

REPORT WORKERS' COMPENSATION FRAUD

Fraud costs everyone. Fraud isn't just committed by unscrupulous workers who feign injuries; submitting false or misleading statements on an application for benefits is also fraud. Suspected Workers' Compensation fraud should be reported to the Workers' Compensation Fraud Hotline at 1-888-372-8330.

PRIVACY RIGHTS

MEDICAL OR REHABILITATION RECORDS IN AN EMPLOYEE'S FILE MAINTAINED BY THE BOARD ARE NOT PUBLIC RECORDS SUBJECT TO PUBLIC INSPECTION AND COPYING UNDER AS 23.30.107. ALL OTHER INFORMATION FILED WITH THE WORKERS' COMPENSATION DIVISION IS AVAILABLE FOR PUBLIC REVIEW UPON REQUEST.

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I. GLOSSARY OF TERMS

AFFIDAVIT OF READINESS FOR HEARING (ARH). Form 07-6107. Official request for a hearing filed by a party swearing they have completed all necessary discovery and are fully prepared for hearing.

AFFIDAVIT OF SERVICE. A statement by an individual that they personally provided/sent certain documents to the parties listed.

ALASKA WORKERS' COMPENSATION ACT (ACT). The statutes that define the rights, benefits and obligations of employers and employees with respect to work related injuries. Most Alaskan employees and employers are covered under the Act. Employers who employ one or more workers must have workers' compensation insurance. An employer must buy the insurance from a licensed insurance company or be self-insured. Your employer cannot require you to pay any part of the insurance premium. If your employer does not have workers' compensation insurance, contact the Workers' Compensation Special Investigations Unit immediately.

ALASKA WORKERS' COMPENSATION BOARD (BOARD). The group of industry and labor members appointed by the governor to three year terms during which they, along with a Hearing Officer from the Division of Workers' Compensation (Division) decide workers' compensation claims. The Board also considers and approves regulations drafted by the Division. Neither the Board nor the Division pay benefits. The Division collects and provides information about the workers' compensation system and benefits, and provides administrative support for the Board.

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

CLAIM. Form 6106. Formally entitled a Workers' Compensation Claim, this is the document filed by an employee to request benefits. This document commences an action before the Alaska Workers' Compensation Board. A Medical Summary must usually accompany this form. A Request for Conference may be filed with this form. The term is also used to generally describe a proceeding (i.e. "Claim") before the Board.

COMPENSATION REPORT. A document provided by the insurer showing what payments have been made to or on behalf of the employee.

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

CONTROVERSION NOTICE. Notice sent by the insurer stating they will no longer pay for the benefits listed and the reasons why they will no longer pay. This denial of benefits can be appealed to the Board by the filing of a Claim along with a Medical Summary.

COVERAGE. Nearly all Alaska employees are covered. Commercial fishers are an exception, but some fish processing workers on floating processing vessels are covered. Other employees not covered include 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 a ruling by the Workers' Compensation Board. If a party disagrees with a Decision & Order, they may file a Petition for Reconsideration, a Request for Modification, or if it is a Final Decision & Order, it may be appealed to the Workers Compensation Appeals Commission, but such actions must be within the time limits prescribed by law.

ENTRY OF APPEARANCE. A document notifying the parties that an attorney or other representative is entering the case on behalf of a party.

INJURY. In this brochure the term refers to an injury or illness caused by work conditions on or after November 7, 2005. Contact the Division if you need information about an injury that happened before that date.

INSURER. In this brochure the term designates the insurance company or a self-insured employer. The insurer, through its adjuster either pays or denies (controverts) compensation or medical benefits if you are injured.

LEGAL MEMORANDA. A document submitted (usually before a Hearing) to the Board by a party, which identifies the relevant issues, presents arguments and cites relevant legal statutes, regulations or legal precedent. Usually, a brief will take the form of presenting facts followed by legal argument, but it may be as simple as a letter setting forth pertinent facts or the history of the 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.

MEDICAL SUMMARY. A listing of medical records in a case. This document must usually accompany a Claim.

OPPOSITION TO AFFIDAVIT OF READINESS. Document filed to oppose the scheduling of a hearing as requested in an Affidavit of Readiness for Hearing. The opposition must state why a hearing should not be set at this time.

PETITION. A request to the Board for some particular action in a proceeding.

PHYSICIAN'S REPORT. Document filed directly by the doctor reporting the EE's current medical condition, recent treatment provided and future treatment plans.

REEMPLOYMENT BENEFITS ADMINISTRATOR. The Division employs a Reemployment Benefits Administrator (administrator) who decides reemployment benefit eligibility evaluation requests, reviews reemployment benefit eligibility evaluations and, if necessary, retraining plans and hears disputes between you and the insurer regarding reemployment benefits.

REPORT OF OCCUPATIONAL INJURY OR ILLNESS. The first document regarding an injury that should be filed with the Division. It establishes that an occupational injury has occurred. This form is completed by the employee and the employer jointly. If either one is unavailable or refuses to complete the form, it can be submitted by either party with an explanation for the uncompleted portion.

REQUEST FOR CONFERENCE. This is a request to the Board to schedule an informal pre-hearing conference to resolve a particular issue or discuss and identify the issues filed on a Claim or Petition. You cannot have a prehearing unless a Petition or Claim has been filed.

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 physician chosen by the Board (SIME).

STIPULATION. An agreement by the parties on a specific issue. Stipulations may require an Order from the Board to be valid.

II. IF YOU ARE INJURED

A. WHAT TO DO IF YOU ARE INJURED:

1. Get first aid or medical care immediately if needed. You may choose the physician. Before changing physicians, read statement number 6 below and “Choice of Doctors” on page 11, for more information. [AS 23.30.095; 8 AAC 45.082]

2. Tell your supervisor, your employer or “the office” about the injury right away. You must give written notice to your employer and the Board within 30 days after the accident or when you think you have an illness caused by work. [AS 23.30.100] The Division provides the “Report of Occupational Injury or Illness” (form 6101) for this purpose. Obtain the form from your employer or the Division. Complete your part of the form and give your employer all the copies. After your employer completes its portion, your employer should give you the yellow copy. If your employer will not give you a form, contact the Division.

3. Write down your employer’s official name and address and the insurer’s name and address. Your employer must post a notice of insurance or self-insurance in three places where employees can easily see it. The employer’s name and address and the insurer’s name and address can be found on the posted notice of insurance. If your employer did not post a notice or if your employer will not give you the insurer’s name when you ask, contact the Division.

4. Write down your supervisor’s, foreman’s, or boss’s name. Also write down the names of the people who saw your accident or the work conditions that may have caused your illness.

5. 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 Board within 14 days of treatment. Give the insurer your doctor’s name and address right away.

6. You may change your treating doctor 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, you may have to pay the doctor’s bills. If your treating doctor refers you to a specialist, this is not a change of doctors.

7. Keep receipts for medicine, actual travel expenses (including mileage) and other costs of your medical care. Give copies of the receipts and the mileage record to the insurer for reimbursement. If you do not keep receipts, you may not be eligible for reimbursement.

8. 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. Do not send them to the Board or the Division as this will slow your payment. 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 figuring your disability benefit rate. Provide the insurer with proof of employer contributions as soon as possible.

9. 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.

10. Immediately tell the insurer when you go back to work, get unemployment benefits, file for social security benefits, or change your address.

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

12. Tell the truth. If you lie or submit false documents to obtain benefits, you are guilty of a crime which is punishable by a maximum fine of \$50,000, imprisonment of up to 10 years, or both. You are also civilly liable to the person adversely affected. [AS 23.30.250]

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

B. WHAT THE INSURER DOES IF YOU ARE INJURED:

The insurer usually learns of your injury from the 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 benefits or controvert (deny) them. (See page 9 for when and how payments are made.) If the insurer denies benefits, it must send you and the Board a Controversion Notice. The notice will explain how to file a written claim with the Board should you dispute the controversion.

Compensation is payable only for those injuries which arise out of and occur during the course and scope of your employment. If the insurer does not believe your injury arose out of and occurred during the course and scope 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. [AS 23.30.235]

III. CALCULATING 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 various ways depending on whether you are paid by the week, month, year, day or hour. (See "A", below) Your weekly compensation rate will be 80% of your spendable weekly wage (gross weekly earnings minus payroll tax deductions), but is subject to certain limits. The Division prepares rate tables that insurers use to figure your weekly disability benefit rate.

A. GROSS WEEKLY EARNINGS: [AS 23.30.220] If you were injured BEFORE November 7, 2005, contact the Division for information on how your gross weekly earnings are figured. If your injury occurred on or after November 7, 2005, your gross weekly earnings are computed as follows:

(1) If at the time of injury your earnings are calculated by the week, the weekly amount is your gross weekly earning. [AS 23.30.220(a)(1)]

(2) If at the time of injury your earnings are calculated by the month, your gross weekly earnings are your monthly earnings multiplied by 12 and divided by 52. [AS 23.30.220(a)(2)]

(3) If at the time of injury your earnings are calculated by the year, your gross weekly earnings are the yearly earnings divided by 52. [AS 23.30.220(a)(3)]

(4) If your earnings are calculated by the day, hour, or by your output, if you are injured, your gross weekly earnings 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. [AS 23.30.220(a)(4)]

(5) If at the time of injury your earnings are not fixed or cannot be ascertained, your earnings will be considered the usual wage for similar services when those services are rendered by a paid employee. You should try to give the insurer proof of what the wages would have been for work similar to your work. [AS 23.30.220(a)(5)]

(6) If your work at the time of injury was calculated by the week under (1) above or by the month under (2) above, and your employment was strictly seasonal or temporary, your gross weekly earnings are 1/50 of all the wages you earned in all occupations in the 12 calendar months immediately before your injury. You must give the insurer proof of your earnings. [AS 23.30.220(a)(6)]

"Seasonal work" means employment that is not intended to continue through an entire calendar year, but recurs on an annual basis. [AS 23.30.220(c)(1)]

"Temporary work" means employment that is not permanent, ends upon completion of the task, job, or contract, and ends within six months from the date of injury. [AS 23.30.220(c)(2)]

(7) If you are injured as a minor, an apprentice, as a trainee in a formal training program, volunteer ambulance attendant, volunteer police officer, volunteer emergency medical technician, or a volunteer fire fighter, contact the Division for information on how your gross weekly earnings will be determined by the insurer.

B. MAXIMUM AND MINIMUM COMPENSATION RATES: Your weekly compensation rate cannot exceed the Maximum Weekly Compensation Rate nor fall below the Minimum Weekly Compensation rate. These rates are determined as follows:

(1) Maximum Weekly Compensation Rate. For injuries occurring prior to July 1, 2000, the maximum weekly compensation rate you could receive was \$700. For injuries occurring on or after July 1, 2000, you cannot receive more than 120% of the State's average weekly wage for compensation benefits. Each December the Commissioner of Labor determines the average weekly wage for all employees in the State. This rate is then used to establish the maximum weekly compensation rate. The maximum weekly compensation rates for injuries occurring on or after July 1, 2000 are as follows:

1. 7/1/00 - 12/31/00	\$762.00
2. 2001	\$767.54
3. 2002	\$791.36
4. 2003	\$814.34
5. 2004	\$832.00
6. 2005	\$848.00
7. 2006	\$875.00
8. 2007	\$901.00
9. 2008	\$939.00
10. 2009	\$987.00

(2) Minimum Weekly Compensation Rate. 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.

C. NON-RESIDENT COMPENSATION RATES: If you move from Alaska or live outside Alaska, the insurer must adjust your compensation rate to reflect a cost of living adjustment. The adjusted rate is the non-resident weekly rate. 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 list of the cost-of-living figures for Alaska and other places in the United States. If you or the insurer believe there is a large difference between the actual cost of living in the area in which you live and the cost-of-living figure on the list, you or the insurer can contact the Division.

IV. WHEN AND HOW PAYMENTS ARE MADE

A. PAYMENT DUE DATE. [AS 23.30.155] No compensation benefits are paid for the first three days of disability unless you are 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, in the case of a deceased worker, to the 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 the check does not close your claim.

B. PENALTIES AND INTEREST. [AS 23.30.155] If payment is not made by the 7th day after payment is due, a penalty equal to an additional 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. Payment is complete when placed in an envelope bearing the correct name and address of record and deposited 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 if you believe a penalty is due.

V. BENEFITS

A. DISABILITY AND IMPAIRMENT BENEFITS: There are three types of disability and one impairment benefit. They are as follows:

(1) Temporary Total Disability (TTD) Benefits. [AS 23.30.185] These 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 is expected.

(2) Temporary Partial Disability (TPD) Benefits. [AS 23.30.200] These benefits are paid if you can return to work but only for less than a full day while recovering (i.e. you're not medically stable). 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. TPD benefits cannot exceed your weekly TTD rate. It is necessary that you give proof of your actual wages to the insurer in order to obtain these benefits. TPD benefits are paid until you reach medical stability or for up to five years, whichever comes first.

(3) Permanent Partial Impairment (PPI) Benefits. [AS 23.30.190] These benefits are paid in addition to temporary disability benefits and are paid to compensate 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, the 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. The doctor rates the percentage of loss. To rate your loss, the doctor must use the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, (Sixth Edition). If the Board decides the permanent impairment cannot be determined under the *AMA Guides*, the impairment rating may be based on the American Academy of Orthopedic Surgeons' Manual for Evaluating Permanent Physical Impairments (1st ed. 1965) or the State of Minnesota, Department of Labor & Industry, Permanent Partial Disability Schedule (July 1, 1993).

Under the *AMA Guides*, the degree of impairment caused by your injury is rated as a percent of the whole person. Alaska law sets the value of the whole person at \$177,000. The insurer therefore figures your PPI benefits by multiplying the percent of the whole person impairment assessed under the *Guides* by \$177,000. The result is then paid in a lump sum unless you are in the reemployment process. [See p. 13, below for an explanation of the reemployment process.] If you are in the reemployment process, PPI benefits are then paid every 14 days at your weekly compensation rate just as you were paid TTD benefits.

(4) Permanent Total Disability (PTD) Benefits. [AS 23.30.180] These 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, industrial 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 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 disability ends or until death. If you received PPI benefits, your PTD benefits will be reduced by the amount of the PPI award, adjusted for inflation.

B. DEATH BENEFITS. In the case of a work related death, the insurer pays \$10,000 for funeral expenses and \$5,000 to the employee's surviving spouse and/or children. In

addition, weekly benefits are paid to the employee's dependents in various amounts which in the aggregate equal the deceased employee's compensation rate for a total disability. Widows, widowers, and children 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. All questions of dependency are determined as of the time of injury or death. Contact the Division for more details about who can qualify as dependents and the calculation of the weekly benefit amount.

C. MEDICAL BENEFITS. [AS 23.30.095] The insurer is obligated to pay medical expenses for up to two years following the injury. Medical expenses may be paid thereafter if ordered by the Board. Insurers usually pay for medical care beyond two years if necessary for the process of your recovery from the injury. Additional elements you should be aware of include the following:

(1) **Choice of Doctors.** You may choose a licensed doctor to treat your injury (including 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.

(2) **Reporting.** Be sure your doctor prepares a report on a Board prescribed "Physician's Report" form for the insurer and the Board. Unless the 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.

(3) **Insurer's Obligation to Pay.** Provide your doctors, the hospital, or other medical providers with the name and address of the insurer 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. 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.

The insurer's obligation to pay medical expenses is limited to the lowest of the usual, customary and reasonable fees for the treatment or service in the community in which it is rendered. If the health care provider's charges are higher, neither you nor the insurer is obligated to pay the difference. 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.

(4) 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 in excess of: 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.

(5) 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 insured. Mileage is reimbursed by the insurer.

If needed 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. According to 8 AAC 45.084(e) "A reasonable amount for meals and lodging purchased when obtaining necessary medical treatment must be paid by the employer if substantiated by receipts submitted by the employee. Reimbursable expenses may not exceed the per diem amount paid by the State of Alaska to its supervisory employees while traveling."

(6) Medical Examinations Requested by the Insurer. At reasonable times, which may be as often as every 60 days, the insurer can ask that you be examined by a doctor of its choice. The insurer must give you at least 10 days' notice of the medical appointment.

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. The insurer pays all costs associated with the examination. If you do not go to the examination, the insurer may terminate compensation payments until you see their doctor.

(7) Examinations Ordered by the Board. If your doctor and the insurer's doctor disagree about your medical condition, the Board may select a physician to examine you. The insurer must pay the costs of this examination and your reasonable transportation

and lodging expenses. Your compensation benefits may be reduced to repay the insurer 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.

D. REEMPLOYMENT BENEFITS.

(1) Requesting Reemployment Benefits. If you were injured prior to November 7, 2005, please contact the reemployment benefits office at (907) 269-4985 for information regarding vocational reemployment benefits. If you were injured on or after November 7, 2005, the following applies:

(a) If the insurer has accepted your claim and you have been totally unable to return to your occupation at the time of injury for 45 consecutive days, the reemployment benefits office must notify you of your rights regarding retraining. If you have not heard from that office by the 60th consecutive day of disability, please contact them by calling (907) 269-4985.

(b) 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 (retraining). The request will be approved if medical documentation is provided by you or the insurer documenting that your injury may permanently keep you from returning to your occupation at the time of injury.

(c) 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 reemployment benefits office is required to assign a rehabilitation specialist to conduct an eligibility evaluation. Please contact the reemployment benefits office at (907) 269-4985 if you have not received notification of an evaluation within ten days of that landmark.

(d) At any time, you and the insurer may stipulate (agree) that you are eligible for retraining without an evaluation.

(2) Qualifying for Reemployment Benefits. Once you have requested reemployment benefits, you will be assigned to a rehabilitation specialist for an eligibility evaluation. If you are assigned for an eligibility evaluation, the rehabilitation specialist must complete the eligibility evaluation and write a report regarding your eligibility for reemployment benefits within 30 days of the assignment. The insurer pays all costs associated with the rehabilitation specialist. If you are not assigned a rehabilitation specialist, the administrator's letter tells you why and what to do if you disagree.

You may be eligible for reemployment benefits if:

(a) a medical provider predicts you will never be physically able to return to the your job at time of injury or other jobs that you have held or received education/training 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.

Within 14 days after the administrator receives the eligibility evaluation report from the rehabilitation specialist the administrator must issue a written decision regarding your eligibility for reemployment benefits. If you are found not eligible, the administrator's letter will explain how to ask the Board to review that decision.

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 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. Be sure to follow the instructions and the time limits in the administrator's letter.

(3) Developing a Retraining Plan. If you choose retraining, the rehabilitation specialist you have selected must write a plan to return you to work. The retraining plan may consist of on-the-job training, vocational (technical or trade) training, academic training (college), self-employment or a combination of those options. The plan selected must provide you with the skills necessary to return you to work in the shortest possible time and at a wage level equal to at least 60% of your wages at the time of injury. Retraining under the plan may last up to two years. The insurer must pay all costs associated with plan development and monitoring (follow-up) and must pay retraining costs up to a maximum of \$13,300. 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.

(4) Disability and Stipend [.041(k)] 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 to be 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.

(5) Reemployment Responsibilities. If you are referred for an eligibility evaluation, you must cooperate and assist with the evaluation. If you are found eligible for reemployment benefits, you must timely select a rehabilitation specialist or elect to receive a dislocation benefit. If you opt to continue with reemployment efforts, you must work with 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 efforts and the insurer may terminate reemployment benefits. If you disagree with the termination, you must ask in writing that the administrator hold a hearing to decide whether you have failed to cooperate.

(6) 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 a Board form, have it notarized and submit it to the insurer and the Board.

IF YOU HAVE QUESTIONS ABOUT REEMPLOYMENT BENEFITS, PLEASE CONTACT THE REEMPLOYMENT BENEFITS SECTION AT 269-4985.

VI. OTHER IMPORTANT INFORMATION

A. WORKERS' COMPENSATION FRAUD. [AS 23.30.250] 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 as defined in AS 11.46.180, and may be punished as provided in AS 11.46.120 - 11.46.150. (Upon conviction of theft by deception you may be punished by a fine up to \$50,000, imprisonment up to 10 years, or both.)

B. 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 (page 23) or an attorney familiar with Alaska workers' compensation law. Call the Division for a list of such attorneys.

C. WHAT TO DO IF YOUR EMPLOYER IS UNINSURED. If your employer does not have workers' compensation insurance, notify the Division's Special Investigations Unit immediately. If your employer agrees to pay benefits, get the agreement in writing. If the employer refuses to pay benefits, file a workers' compensation claim against your employer. A copy of your claim will be forwarded to the Workers' Compensation Benefits Guaranty Fund. This fund was established to pay benefits to injured workers whose employers were uninsured at the time of injury. If your employer is found responsible for your benefits and fails to pay, this 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) The injured worker must have been an employee of an uninsured employer at the time of injury.

(2) The employee's work for the employer must have been the substantial factor in the cause of the injury or illness.

(3) The injured worker must file a claim for benefits against the uninsured employer within two years of the injury, or knowledge that an injury or illness was work related.

(4) The injured workers' claim against the employer must result in an order by the Board for the employer to pay benefits to the injured worker.

(5) The employer must fail to pay as ordered by the Board.

(6) If the employer fails to pay benefits as ordered by the Board, the employee must file a claim against the Fund and the Fund will commence the payment of benefits.

If the Fund pays workers' compensation benefits to an injured worker of an uninsured employer, the Fund has the legal right to recover those costs from the uninsured employer, including legal expenses. Therefore, it is in the uninsured employer's best interest to pay benefits to the injured worker.

D. RELEASES. 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 part(s) as those injured. If you are asked to sign a release that you feel is not appropriate, you must file a request 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.

E. 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 claims 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.

F. 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.

G. EXEMPTIONS FROM DEBT AND TAXES. Disability benefits are not taxable. If a creditor has a judgment against you, the creditor can take part 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.

H. OVERPAYMENTS AND ADVANCES. The insurer sometimes makes advance payments or overpays benefits. The insurer may keep up to 20% of 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 (page 23).

I. APPLYING FOR WORK AFTER YOU RECOVER. After you recover and apply for work, you should be aware of AS 23.30.022, which 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. The Americans with Disabilities Act (ADA), also limits prospective employers’ right to ask about your physical condition (health). 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.

J. SOCIAL SECURITY OFFSET. Your workers’ compensation disability or death benefits may be reduced if you or your dependents receive social security benefits. You should tell the insurer when you file for social security benefits or if you obtain social security benefits.

K. 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 Workers’ Compensation Division for information and forms (page 23).

L. 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 Compromise and Release Agreement (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 approved by the Board. 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.

M. 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 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 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 a list of attorneys.

N. 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 for work done on your case without Board approval. However, the attorney can have you pay your legal costs without Board approval. You do not have to pay the insurer's attorney's fees and legal costs unless you knowingly lie to get benefits.

VII. TIME LIMITS

A. REPORTING YOUR INJURY. [AS 23.30.100] Within 30 days after the injury or death, you or your dependents must give the employer and the Board written notice of the injury or death. If you do not give this notice, your benefits will be barred unless the Board excuses your failure to give notice. If 30 days have passed and you have not given your employer written notice, contact the employer and the Workers' Compensation Division immediately (page 23).

B. FILING A CLAIM. [AS 23.30.105] If the insurer denies benefits, you must file a written claim with the Board within two years after the date you knew the nature of your disability and its connection with your work and after disablement. A written claim is called a Workers' Compensation Claim (WCC) and operates to formally commence an action against the insurer for benefits. If you fail to file a claim within two years, you may lose your right to benefits.

If the insurer voluntarily pays and then terminates or controverts disability benefits, you must file a written claim within two years after the last payment of disability benefits. Dependents may lose their right to death benefits unless they file a claim within one year after the death.

C. REQUESTING A HEARING. [AS 23.30.110(c)] If you file a WCC and the insurer controverts the claim, you must request a hearing before the Board within two years of the date of the controversion or your right to the benefits will be denied. If you ask for a hearing and then later ask for a continuance of the hearing, the two-year time limit starts to run again from where it stopped when the hearing was originally requested.

VIII. WORKERS' COMPENSATION FORMS

The following forms are available at the Division offices or on the internet at:

http://www.labor.state.ak.us/wc/pdf_list.htm

A. REPORT OF OCCUPATIONAL INJURY OR ILLNESS (6101). You must complete this report and provide it to your employer within 30 days following your injury. You must complete the employee's portion of the form (the top half) and give the form to your employer to complete and distribute. The form is available from your employer and from the Division.

B. PHYSICIAN'S REPORT (6102). This form is filled out by the physician each time the injured employee is treated. It is this form which must be completed by the physician and forwarded to the insurer with a bill to trigger the insurer's obligation to pay medical expenses.

C. MEDICAL SUMMARY (6103). This form is used to list medical reports to be provided to the Board and the insurer. This form usually accompanies a Workers' Compensation Claim for Benefits (form 6106).

D. COMPENSATION REPORT (6104(B)). This form is completed by the insurer and details the formula used to calculate benefits and the payments made to the employee.

E. CONTROVERSION NOTICE (6105). This form is used by the adjuster to deny some or all benefits. If you disagree with the insurer's denial of your benefits, you must file a written claim (WCC) and request a hearing before the Board (forms 6106 and 6107).

F. WORKER'S COMPENSATION CLAIM (6106). This form is used to file a written claim when a dispute cannot be resolved between the employee and the adjuster. Filing a Worker's Compensation Claim formally commences an action before the Board for benefits. The insurer has 20 days to respond to the application after it is served by the Board.

G. AFFIDAVIT OF READINESS FOR HEARING (6107). This form is filed to request a hearing before the Board. A Worker's Compensation Claim (form 6106) or a Petition (form 6111) must be filed before an Affidavit of Readiness for Hearing can be submitted.

H. PETITION TO JOIN SECOND INJURY FUND AND CLAIM FOR REIMBURSEMENT (6109). This form is used by the insurer to request reimbursement from the Second Injury Fund for compensation payments made to an injured worker. It does not affect your receipt of benefits but may allow the insurer to seek recovery of your disability benefits from the Second Injury Fund.

I. PETITION (6111). This form is used to join additional employers, terminate benefits or raise issues not claimed in a Workers' Compensation Claim (form 6106).

J. SUBPOENA (6112). This form is used to compel persons to appear before the Board or at a deposition or to tender documents requested. Contact the Division if you wish to have a subpoena issued or if you wish to quash a subpoena issued at the insurer's request.

K. COMPROMISE AND RELEASE AGREEMENT SUMMARY (6117). This form is used to summarize a Compromise and Release (settlement) agreement reached by the parties to a workers' compensation claim. It is prepared by the insurer for reporting purposes.

L. DEATH BENEFITS REPORT (6118). This form is used by the insurer to itemize payments to the deceased's dependents.

M. EMPLOYERS' NOTICE OF INSURANCE (6120). This completed form must be posted in three conspicuous places on your employer's premises. If this notice is not posted, it may mean your employer is not insured for work-related injuries.

O. REQUEST FOR RELEASE OF INFORMATION (6121). This form is used to request copies of Board records from the Division.

P. REQUEST FOR CONFERENCE (6135). This form is used to request a prehearing conference while a Workers' Compensation Claim (form 6106) or Petition (form 6111) is pending.

Q. REQUEST FOR CROSS-EXAMINATION (6174). This form is used to request cross-examination of the author of any document relied upon by a party. The form is used by all parties to a dispute.

R. AFFIDAVIT OF COMPENSATION RATE LESS THAN \$154 (6175). This form is used to justify paying a compensation rate less than the minimum rate after the insurer has received wage documentation from the employee.

S. WAIVER OF REEMPLOYMENT BENEFITS. This form is used to waive reemployment benefits.

T. RELEASE OF MEDICAL INFORMATION. This form is used by the insurer to obtain records related to a workers' compensation claim or injury.

U. SECOND INDEPENDENT MEDICAL EVALUATION (SIME) FORM (6147). This form is used to request a medical evaluation by a physician selected by the Board.

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 the letter.

IX. CONTACT US

IF YOU STILL HAVE QUESTIONS... or if you need additional information please call, write or come by the nearest Workers' Compensation Division office:

ANCHORAGE:

3301 Eagle Street
Suite 304
Anchorage, Alaska
99510-7019
(907) 269-4980

FAIRBANKS:

675 Seventh Avenue
Station K
Fairbanks, Alaska
99701-4593
(907) 451-2889

JUNEAU:

1111 W. Eighth Street
Room 305
P.O. Box 115512
Juneau, Alaska
99811-5512
(907) 465-2790

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