EMPLOYEE: This report is for your information. Keep it for your records.
Read important information about your rights on back.

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

COMPENSATION REPORT

AWCB Case Number Only

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
4. Address	5a. ◯ Single ◯ Married / 5b. Number of Dependents	6. Social Security Number
City State Zip Code Telephone	(AWCB Use Only)	7. Birth Date
8. Employer	9. Insurer/Adjusting Company	
10. Address	11. Address	
City State Zip Code Telephone	City State Zip Code Telephone	

12. **COMPENSATION RATE --COMPLETE FOR INITIAL PAYMENT OR RATE CHANGE**
Employee's wages were calculated:

- ☐ a. Weekly = $_____ (weekly earnings) gross weekly earnings at time of injury (attach wage documents).
- ☐ b. Monthly = $_____ (monthly earnings) x 12/52 = $_____ gross weekly earnings (attach wage documents).
- ☐ c. Yearly = $_____ (yearly earnings) ÷ 52 = $_____ gross weekly earnings (attach wage documents).
- ☐ d. Day, hour, or output = earnings during either of the two calendar years immediately preceding the injury, whichever is most favorable to the employee $_____ ÷ 50 = $_____ gross weekly earnings (attach wage documents).
- ☐ e. Worked less than 13 calendar weeks immediately before injury = $_____ earnings ÷ 13 = $_____ gross weekly earnings (attach wage documents).
- ☐ f. Wages not fixed at time of injury, explain how earnings determined: _____
- ☐ g. By the week or by the month, and employment is exclusively Seasonal/Temporary: = earnings for 12 calendar months immediately preceding date of injury $_____ ÷ 50 = gross weekly earnings;
- ☐ h. 2 employers or more, use applicable methods above.
- ☐ i. Minor, apprentice, or trainee.
- ☐ j. Volunteer policeman, etc.
- ☐ k. Offset: Social Security (#39) or 155(i) (#40) (attach wage documents).
- ☐ l. Paid $110 minimum, explain _____

13.	b. Gross Earnings	Gross Weekly Earnings - Tax & FICA x 80% =	Weekly Rate*	Maximum or Minimum
☐ a. Alaska TTD, PTD, Death				
☐ c. Alaska TPD ☐ Offset 41K	d. Weekly TTD Rate	Weekly Earnings Capacity - (- Tax & FICA x 80% =) =	Weekly Rate*	Maximum or Minimum
☐ e. Out-of-state TTD, PTD, Death	f. Alaska TTD Rate	COLA Ratio x	COLA Weekly Rate % =	Date Left Alaska

14. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date:_____ ☐ h. OTHER (Explain) _____

15. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount

(If additional space is needed, use chart on reverse.) TOTAL

16. Impairment Rating: _____% of $177,000 Whole Person = $ _____

17. ☐ Permanent impairment compensation was paid in a lump sum. (Enter amount in No. 15 and 16.)
☐ If permanent impairment benefits not paid in a lump sum, enter date Employee requested reemployment benefits. Date:_____

18. a. Date Disability Began	b. First Payment Date	19. Date Disability Ended	20. **TURN OVER AND COMPLETE ITEM 20 ON REVERSE.**

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NONPAYMENT.

21. ☐ Returned to Work Date:_____
◯ At New Job ◯ At Same Job
Occupation _____
Weekly Pay Rate $ _____

22. ☐ Released for Work
Date:_____
◯ Regular Work
◯ Modified Work

23. ☐ Medical Stability
25. ☐ C.O.L.A.
27. ☐ Recomputation
29. ☐ Other

24. ☐ Compromise and Release
26. ☐ Controversion (Attach 07-6105)
28. ☐ Board Order

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

30. Name and Title of Person Submitting Report (Type or Print)	31. Signature	32. Date

33. Address (If Different From No. 11) City State Zip Code Telephone

34. Employee's Name (Last, First, Middle Initial)

35. Report Date

20. a. Employee Attorney Fees $ _____ b. Late Report Penalties $ _____ c. Employer Attorney Fees $ _____

d. Medical $ _____ e. Second Injury Fund $ _____ f. Reemployment Plan Cost $ _____

g. Reemployment $ _____ ☐ SIF Check Attached h. Interest $ _____

i. Other (Explain) _____ $ _____

36. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
					FRONT PAGE TOTAL	
					TOTAL	

37. SOCIAL SECURITY OFFSET. (Applies only to some recipients of Social Security Benefits.)

a. Social Security Retirement or Survivors Benefits (AS 23.30.225(a)). How the reduced weekly compensation was figured:

(1) SS Monthly Benefit _____ x 12/52 = SS Weekly Benefit _____ x 1/2 = Reduction _____ (2) Weekly Rate _____ - Reduction _____ = Reduced Weekly Rate _____

b. Social Security Disability Benefits (AS 23.30.225(b)). How the reduced weekly compensation rate was figured:

(1) SS Monthly Benefit _____ x 12/52 = SS Weekly Benefit _____ (2) Gross Weekly Earnings _____ x 80% = Max. Weekly Payment _____ - SS Weekly Benefit _____ = Reduced Weekly Rate _____

38. Remarks

39. EXPLANATION AND ABBREVIATIONS

a. Suspension. Item 14d means the employer/insurer has stopped compensation payments expecting to pay more compensation later (usually the difference between the minimum and the documented rate). See paragraph 40a below for effect on medical benefits.

b. Termination. Item 14c means the employer/insurer has stopped compensation payments with the belief all compensation due has been paid. See paragraph 40a below for effect on medical benefits.

c. In Item 15b, the following abbreviations means the following types of disability:

Dth = Death Benefits (Attach 07-6118) TTD = Temporary Total Disability PPI = Permanent Partial Impairment 25% = 25% Late Payment Penalty
TPD = Temporary Partial Disability PTD = Permanent Total Disability 41 K = Reemployment

d. Knowledge Date under Item 14g means the date the employer/insurer learned about the employee's resumed disability or PPI rating.

e. SIF in Items 14b and 20e means Second Injury Fund. The insurer/employer makes this payment directly to the Alaska SIF, not the employee. SIF payments must be attached to the Board's annual report. The SIF payment does not affect the amount of compensation an employee receives.

40. TO EMPLOYEE (or other claimants in the case of death): READ CAREFULLY

a. This report means the insurer/employer has begun, stopped or changed your compensation payments. The insurer/employer should continue to pay for medical treatment for your injury for at least two years after your injury date. Although the law lets the insurer/employer stop medical payments two years after your injury date, you may file a written claim asking the Alaska Workers' Compensation (AWC) Board to authorize additional medical payments for treatment necessary to your recovery.

b. YOU HAVE TWO YEARS FROM THE DATE OF THE COMPENSATION PAYMENT TO FILE A WRITTEN CLAIM FOR ADDITIONAL COMPENSATION PAYMENTS.

c. If the AWC Board has issued a decision regarding your claim, you have one year from the date of the Board's order to file a written claim for a modification because of a change of condition or a mistake. If you have settled your claim by a compromise and release agreement which was approved by the AWC Board and later want to claim more benefits, contact the nearest AWC Board office for information. Attempts to get more benefits after an agreement seldom succeed.

d. IF YOU BELIEVE THIS REPORT CONTAINS MISTAKEN INFORMATION, IF PAYMENTS HAVE STOPPED AND YOU CANNOT WORK BECAUSE OF YOUR INJURY, OR IF YOU HAVE QUESTIONS, CONTACT THE PERSON WHO SUBMITTED THE REPORT AT THE PHONE NUMBER OR ADDRESS GIVEN ON THE FRONT OF THIS REPORT. IF YOU AND THAT PERSON CANNOT AGREE, OR IF YOU STILL HAVE QUESTIONS, CONTACT THE NEAREST AWC BOARD OFFICE. SEND COPIES OF YOUR WAGE DOCUMENTS TO THE INSURER/EMPLOYER: DO NOT SEND THEM TO THE AWC BOARD.

ALASKA WORKERS' COMPENSATION BOARD

Anchorage
3301 Eagle Street, Suite 304
Anchorage AK 99503
Telephone: 907-269-4980

Fairbanks
675 Seventh Avenue, Station K
Fairbanks, AK 99701-4586
Phone: 907-451-2889

Juneau
P.O. Box 115512, Juneau AK 99811-5512
1111 W 8th St Rm 305, Juneau AK 99801
Telephone: 907-465-2790