EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:
Your employer is insured by:

ZURICH AMERICAN INSURANCE COMPANY
Insurer

1299 ZURICH WAY
Street and Number

SCHAUMBURG | IL | 60196-5870
City | State | Zip Code

For the period from 7/1/2021 Through 7/1/2022

ZURICH CLAIMS SERVICES
Adjusting Company

PO BOX 49547
Street and Number

COLORADO SPRINGS | CO | 80949- | 800-987-3373
City | State | Zip Code | Telephone

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

OREGON STATE UNIVERSITY
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.

POSTING LOCATION: [OREGON STATE UN] 18990 BEAN CREEK RD, PO BOX 545, COOPER LANDING, AK 99572

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POSTING LOCATION: [OREGON STATE UN] 706 OUIDA WAY, NORTH POLE, AK 99705