EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

SCHAUMBURG			60196-5870
City		State	Zip Code
For the period from 7/1/2021	Through		
ZURICH CLAIMS SERVICES Adjusting Company		•	
PO BOX 49547			
Street and Number	CO.	80040	900 007 227
Street and Number COLORADO SPRINGS City This insurance pays benefits for job-conne Compensation Act		80949- Zip Code or death as provided	800-987-337 Telephone by the Alaska Workers'
PO BOX 49547 Street and Number COLORADO SPRINGS City This insurance pays benefits for job-conne Compensation Act OREGON STATE UNIVERSITY Employer	State cted injuries, illnesses o	Zip Code	Telephone
COLORADO SPRINGS City This insurance pays benefits for job-conne Compensation Act OREGON STATE UNIVERSITY	State cted injuries, illnesses o	Zip Code	Telephone
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COLORADO SPRINGS City This insurance pays benefits for job-conne Compensation Act OREGON STATE UNIVERSITY Employer	State cted injuries, illnesses o	Zip Code	Telephone

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.

EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured	d by:			
ZURICH AMERICA	N INSURANCE CON	MPANY		
Insurer	,			
1299 ZURICH WAY Street and Number				00400 5070
SCHAUMBURG			State	60196-5870 Zip Code
City			State	—,
For the period from 7/1/2	021	Through		
ZURICH CLAIMS S Adjusting Company	SERVICES			
PO BOX 49547 Street and Number				
	NGS	CO	80949-	800-987-3373
COLORADO SPRI	NGS	State	Zip Code	Telephone
OREGON STATE Employer	UNIVERSITY			
Ву				
Title				
Witness				
Witness				
Compensation Division of Injury or Illness" form from	an 30 days from injury or c written notice of a job-relate om your employer for this p	urpose	55, Of GOURT. OOK 1170	,
If you have questions at insurer at the above add	oout your rights or benefits Iress and the Alaska Work	under the Ala ers' Compens	ska Workers' Compe ation Division at the	ensation Act, contact the nearest office listed below:
	EVIDBVIKA	2	JUNEAU	J

(907) 269-4980 NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.

Fairbanks AK 99701-4531

PO Box 115512

(907) 465-2790

1111 W 8th St Rm 305

Juneau AK 99811-5512

FAIRBANKS

(907) 451-2889

675 7th Ave

Station K

ANCHORAGE

Suite 304

3301 Eagle Street

Anchorage AK 99503