EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

HARTFORD INS CO OF THE MIDWEST
Insurer

ONE HARTFORD PLAZA
Street and Number

HARTFORD | CT | 06155
City | State | Zip Code

For the period from 07/01/2024 Through 07/01/2025

HARTFORD INSURANCE COMPANY OF THE MIDWEST
Adjusting Company

ONE HARTFORD PLAZA
Street and Number

HARTFORD | CT | 06155 | 800-327-3636
City | State | Zip Code | Telephone

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

DREXEL 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 Avenue
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.

Form 07-6120 (Rev 05/2012)
Form WC 88 54 01 H Printed in U.S.A.