

# EMPLOYER'S NOTICE OF INSURANCE

## TO THE EMPLOYEES OF THE UNDERSIGNED:

**Your employer is insured by:**

Twin City Fire Insurance Company

Insurer

THE HARTFORD BUSINESS SERVICE CENTER, 3600 WISEMAN BLVD

Street and Number

SAN ANTONIO

TX

78251

City

State

Zip Code

For the period from

07/01/26

Through

07/01/27

Twin City Fire Insurance Company

Adjusting Company

12009 Foundation Place

Street and Number

Rancho Cordova

CA

95670

(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.

UNIVERSITY OF NEW MEXICO

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.