EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

ZURICH AMERICAN INSURANCE COMPANY OF ILLINOIS
Insurer

1400 American Lane
Street and Number

Schaumburg	IL	60196
City	State	Zip Code

For the period from _____ Through _____

Adjusting Company

P.O. Box 981030
Street and Number

West Sacramento	CA	95798	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

WMBE PAYROLLING, INC.
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 Seventh Avenue
Station K
Fairbanks AK 99701-4586
(907) 451-2889

JUNEAU
PO Box 115512
1111 W 8th St Room 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.