ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3455 HLAB HB 6

331

February 10, 1984

MEMO TO THE FILE

Insured : Insulation Services
Claimant : Joe Richardson
Loss of : 6/11/83
Our File : 83-1604WRS

The Second Injury Fund has petitioned the Board for a penalty for late compensation reporting requesting $125.00 for a report being two days late. This refers to compensation report dated September 6, 1983, reflecting a payment of August 22, 1983. At that time, we were paying temporary total disability benefits on a two week basis, and when file came up on diary for payment of compensation, we checked with the doctor's office on September 6, and found that claimant had not been seen since July 15, 1983. We therefore suspended compensation for lack of recent medical information. This suspension was done promptly on September 6, after contacting the doctor's office on September 6. This was how we were instructed to do this to show why there might be a two week lapse from the payment date to the submission of the compensation report. We don't understand how it can be made any more clear than it was in the report.

This is not a late report situation, and should be resisted.

Yours very truly,

Dick Stone
Senior Adjuster

WRS/jrh

dw 2-21

Insulation Services Inc (SIF-FPR)
Northern Adjusters
By AWCB on 2-1-84 [illegible]

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P. O. Box 1149
Juneau, Alaska 99811

AWCB JUNEAU FEB 1 1984

PETITION

(Not to be used by injured employee)

AWCB Case Number: 311557

1. Employee's Name (Last, First, Middle Initial): Richardson Joe R.	2. Insurer Claim No.: 831604 WRS	3. Date of Injury: 06/11/83
4. Address: SR 20145 C		5. Social Security Number: 561-39-8509
City: Fairbanks State: AK Zip Code: 99701 Telephone:		6. Date of Birth: 03/02/60
7. Employer: Insulation Services Inc.	8. Insurer: Northern Adjusters/Employers Casualty	
9. Address: Pouch 340060	10. Address: 2609 Arctic Blvd.	
City: Prudoe Bay State: AK Zip Code: 99734 Telephone:	City: Anchorage State: AK Zip Code: 99503 Telephone: 272-748[illegible]	

REASON FOR PETITION - CHECK APPROPRIATE BOXES AND COMPLETE QUESTIONS IN DETAIL.

☐ JOIN ADDITIONAL EMPLOYER AND/OR INSURER: (ATTACH PROOF OF SERVICE ON EMPLOYER AND/OR INSURER)

11. Name of Employer to be Joined	12. Insurer
13. Address	14. Address
City State Zip Code	City State Zip Code
15. Dates Injured Employee Worked for Employer to be Joined	16. Dates of Coverage (Use when joining only Insurer)
17. Date of Alleged Injury	18. Nature of Alleged Injury

If more than one employer and/or insurer to be joined, attach additional page and provide above information for each employer and/or insurer.

☐ PETITION TO TERMINATE BENEFITS (CHECK TYPE TO BE TERMINATED):

19. ☐ Temporary Total Disability ☐ Temporary Partial Disability ☐ Permanent Partial Disability ☐ Permanent Total Disability ☐ Medical Benefit

☐ Other:

20. Reason for termination:

21. If you are seeking termination of temporary compensation and allege the disability is permanent, report total compensation paid:

Type	From	Through	Weeks and Days	Rate	Amount
				$	$
				$	$
				$	$
				$	$

22. Date When Disability Became Permanent

☒ OTHER (STATE IN DETAIL BELOW: ATTACH ADDITIONAL PAGE IF NECESSARY)

For Board order for late reporting fine of $ 125.00 under AS 23.30.155(c) because the compensation report for the payment made August 22, 1983, was 2 days late. SIF requests this determination based on the documents filed with the Board in this case.

COMPLETE AND ATTACH A MEDICAL SUMMARY (Form 07-6103).
ATTACH PROOF OF SERVICE

23. Name of Individual Submitting this Form (Print or Type): J. Paul House	24. Signature: J Paul House	25. Date: 1-31-84
26. Address: Second Injury Fund, P.O. Box 1149, Juneau, Alaska 99802		
27. Attorney's Name and Firm Name (If Represented)		28. Telephone
29. Attorney's Address City	State	Zip Code

Form 07-6111 (11/82)

MAIL TO ALASKA WORKERS' COMPENSATION BOARD

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P. O. Box 1149
Juneau, Alaska 99811

COPY SERVED ON
Insulation Services Inc (Employer)
Northern Adjusters Inc
By AGREEMENT OF 2-1-84 OR
READINESS TO PROCEED

RECEIVED

AWCB Case Number
311557

BEFORE YOU COMPLETE AND SUBMIT THIS FORM, READ CAREFULLY.

NEA - ARCH

1. Use only to request the scheduling of a pre-hearing or hearing after employee has filed an "Application For Adjustment of Claim" (Form 07-6106) or employer/insurer has filed a "Petition" (Form 07-6111)
2. Note that once a hearing has been scheduled, a continuance will be permitted only for good cause following a written stipulation filed with the Board before the hearing or an oral motion at the time for the hearing. If a continuance is granted, there may be a significant delay before your case is rescheduled.
3. You should complete and submit this form only if you are fully prepared for a hearing.
4. Plan to be present at the hearing in person or represented by an attorney.

AWCB JUNEAU FEB 1 1984

1. Employee's Name (Last, First, Middle Initial)				2. Insurer Claim Number	3. Date of Injury
Richardson, Joe R.				831604 WRS	06/11/83
4. Address					5. Social Security Number
SR. 20145C					561-39-8509
City	State	Zip Code	Telephone		6. Date of Birth
Fairbanks	AK	99701			03/02/60
7. Employer				8. Insurer/Adjusting Company	
Insulation Services Inc.				Northern Adjusters/Employers Casualty	
9. Address				10. Address	
Pouch 340060				2609 Arctic Blvd.	
City	State	Zip Code	Telephone	City State Zip Code Telephone	
Prudoe Bay	AK	99734		Anchorage AK 99503 272-7484	

Before your case will be scheduled for a pre-hearing or hearing, you MUST comply with the following instructions:

Section 1

11. Complete the entire form except (a) Section 4 if requesting a pre-hearing, or (b) Section 3 if requesting a hearing.
12. Attach a "Medical Summary" (Form 07-6103).
13. Attach proof of service upon opposing parties of the "Medical Summary" form and this form.
14. Mail this form to the Board's address in the city you want the pre-hearing or hearing held. If you request "Other", mail to the Board's Juneau address.

Section 2

15. The ☐ Employee, ☐ Employer, ☐ Insurer, or ☒ ~~Physician~~ Second Injury Fund requests that this case be decided on written record contained in the Board's file and no in person hearing be held. set for a ☐ Pre-hearing or ☐ Hearing in:

☐ Anchorage
Pouch 7-019
Anchorage, Alaska 99510
(907) 264-2424

☐ Fairbanks
675 7th Avenue
Station "J"
Fairbanks, Alaska 99701
(907) 452-1509

☐ Juneau
Box 1149
Juneau, Alaska 99811
(907) 465-2790

☐ Other (Check one)
☐ Ketchikan
☐ Sitka

16. Employee is now receiving compensation payments: ☐ YES ☐ NO Weekly Rate $_____

Section 3

17. A pre-hearing is requested to:

☐ Frame Issues, ☐ Record Stipulations, ☐ Join Necessary Parties or ☐ Other (Explain):_____

Section 4

18. A regular hearing is requested. Check additional issues not listed in the "Application for Adjustment of Claim" or "Petition":

☐ Temporary Total Disability
☐ Temporary Partial Disability
☐ Permanent Partial Disability
☐ Permanent Total Disability
☐ Medical Costs
☐ Transportation Costs
☐ Attorney Fees
☐ Penalty
☐ Compensation Rate (Average Weekly Wage Adjustment)
☐ Review of Rehabilitation Plan
☒ Other Penalty for late reporting

19. I expect to present _____ witnesses, including _____ medical witnesses, and estimate the time required for my portion of the hearing will be _____ minutes.

20. Name of Individual Submitting this Form (Print or Type)	21. Signature	22. Date
J. Paul House	J. Paul House	1/31/84

23. Address: Second Injury Fund, P.O. Box 1149, Juneau, AK 99802 (City / State / Zip Code)

24. Attorney's Name and Firm Name (If represented) / Telephone

25. Attorney's Address / City / State / Zip Code

Form 07-6107 (Rev. 7/82)
Formerly AOL 143

NOTE: If the party receiving a copy of this form is not ready for a hearing, an objection should be filed immediately.

EMPLOYEE - READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 311557

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
Richardson, Joe R.	831604WRS	6 / 11 / 83
4. Address	AWCB JUNEAU SEP 0 9 1983 9-7-83	**5. Social Security Number**
SR 20145C		561 - 39 - 8509
City: Fairbanks State: AK. Zip: 99701 Telephone:		**6. Birthdate** 3 / 2 / 60
7. Employer	**8. Insurer/Adjusting Company**	
Alaska Int'l. Constructors	Employers Cas./Northern Adjusters, Inc.	
9. Address	**10. Address**	
P O Box 1410	2609 Arctic Blvd.	
City: Fairbanks State: AK. Zip: 99701 Telephone:	City: Anchorage State: AK. Zip: 99503 Telephone: 272-7484	

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: / / (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or a. prentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? ____

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured. ____

14. RATE $	15. HOW RATE WAS FIGURED			
☐ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $	Employee Avg. Wk. Wage ÷ 52 weeks = $	Alaska Weekly Rate X 66 2/3% = $	Alaska Max. or Min. $
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity −$	Difference =$	Alaska Weekly Rate X 66 2/3% = $ / Alaska Max. or Min. $
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate X $ / State Weekly Rate = $

(1) State or Country ____ (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☒ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
8/22/83	TTD	6/12/83	8/21/83	9	$ 259.98	$ 2339.82
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 2339.82

18. Impairment Rating: ____% of ____ ; ____% of ____ ; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? ____

20. a. Date Disability Began 6 / 12 / 83
b. First Payment Date 7 / 12 / 83
21. Date Disability Ended unknown /

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ ____
e. Second Injury Fund ☐ $ ____ Check to SIF Attached f. Rehabilitation $ ____
g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work / / (Date) ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____
24. ☐ Released for Work Date / /
☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☒ Lack Recent Medical Report

33. Remarks:
Checked with doctor's office on 9/6/83 and found claimant had not been seen since 7/15/83.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Richard Stone, Adjuster	Richard Stone	9 / 6 / 83

37. Address (If different from No. 10) ____ City ____ State ____ Zip ____ Telephone ____

Form 07-6104 (Rev. 6/82) EXPLANATIONS AND INSTRUCTIONS ON BACK

To: Employers Casualty Compa
Attn: Jim Mays
P.O. Box 2759
Dallas, TX 75221

☒ 2609 Arc[illegible]
Anchorage, Ala[illegible]9503
(907) 272-7484

☐ P.O. Box 536
Kenai, Alaska 99611
(907) 283-4462

☐ 708 3rd Ave.
Fairbanks, Alaska 99701
(907) [illegible]1171

☐ P.O. Box 1407
Juneau, Alaska 99802
(907) [illegible]4104

Your No. 83-16-00103-001 Our No. 83-1604WRS Insured Insulation Services

FOLD

Policy No. _____ Date Loss 6/11/83 Claimant Joe Richardson

Date August 31, 1983

Enclosures: Physician's Report

Dear Jim:

This will supplement my report of July 27, 1983, on the above captioned claim.

I contacted the claimant on August 22, and found he is still having problems. The last time he saw a doctor was August 17, so we should be receiving a report in the near future. The claimant has not been released for work. We will look for something definitive in the next two weeks regarding a release for work, or return to work.

Please diary your file 30 days for our next status report.

Yours very truly,

Dick Stone
Senior Adjuster

WRS/jrh

DETACH FOR FILE

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P.O. Box 1149, Juneau, Alaska 99811

PHYSICIAN'S REPORT

☐ INITIAL Employee: Sections 1 & 2 Physician: Sections 3 & 4 ☐ PROGRESS Physician: Sections 1 & 4

AWCB Case Number

SECTION 1

1. Employee's Name (Last, First, Middle Initial): Richardson, Joe R.
2. Insurer Claim No.
3. Injury Date: 7,8,83
4. Address
5. Sex: X Male ☐ Female
6. Social Security Number: 561-39-850
City State Zip Code Telephone
7. Birthdate: 3,2,59
8. Employer: Insulation Services
9. Insurer: Northern Adjusters
10. Address
11. Address
City State Zip Code Telephone
City State Zip Code Teleph

SECTION 2

12. Date Last Worked: / /
13. Was Body Part Injured Before? ☐ No ☐ Yes If yes, when and describe:
14. Describe Injury and Tell How It Happened:
15. Have You Seen Any Other Doctor for this Injury? ☐ No ☐ Yes If yes, list name and address:
16. Hospitalized as Inpatient? Name of Hospital ☐ No ☐ Yes

SECTION 3

17. YOUR First Treatment Date: / /
18. Describe Complaints:
19. Fully Describe Findings on First Examination (Specify Right or Left):
20. Diagnosis
21. X-Rays? ☐ No ☐ Yes X-Ray Diagnosis:
22. Is Condition Work Related? ☐ No (Explain): ☐ Yes ☐ Undetermined (Explain):
23. Describe Treatment (and/or Attach Chart Notes): See attached
24. Treatment Date(s) Since Last Report: 9,14,83 / / / / / /
25. Next Treatment Date: / /
26. Estimate Length of Further Treatment: ____ Days ____ Weeks ____ Month
27. Date Discharged From Treatment: / /
28. Medically Stationary ☐ No ☐ Yes
29. Will Vocational Rehabilitation Be Needed? ☐ No ☐ Yes ☐ Undetermined
30. Will Injury Result In Permanent Impairment? ☐ No ☐ Yes ☐ Undetermined
31. Impairment Rating:
32. Factors on Which Rating Is Based:

SECTION 4

33. Released for work: ☐ No Estimate Length of Disability: ☐ 1-3 Days ☐ 4-14 Days ☐ 15-21 Days ☐ 22-28 Days ☐ More: ____ Weeks ____ Month
☒ Yes ☐ Regular Work Date: / / ☐ Modified Work Date: / / Give Limitations:
34. Remarks (and/or Attach Chart Notes): See attached

RECEIVED
SEP 26 1983
WA - ANCH

35. If Case Referred to Another Physician, State Name and Address: N/A
36. Medical Aid Account
37. Physician's Name and Degree (Print or Type): GEORGE A. BROWN, M.D.
PROFESSIONAL CORPORATION
1919 Lathrop
Suite No. 124 Drawer No. 9
Fairbanks, Alaska 99701
(907) 452-5275
38. Physician's Signature: George A. Brown
39. Report Date: 9,19,83
40. Address City State Zip Code
41. Telephone

SEE INSTRUCTIONS ON BACK

Joe L. Richards

7-15-83 First injured lt ankle twisting it on a rock at work 6.15.83. Reinjured ankle 7.8.83 twisting it walking on a plywood floor that had a hole in it. Seen for Kelly. No meds NKA

He injured his ankle twisting it on a rock at work on 6-15-83. Casted for approximately three weeks and then returned to work when the cast was removed. Reinjured the ankle on 7-8-83.

EXAM: He has some swelling laterally although clinically the ankle is stable both medially and laterally to stress testing. One can palpate the lateral ligament. He states that the x-rays were within normal limits. The x-rays are not here for review today. He has full dorsiflexion, plantarflexion of the ankle. He was placed in a Cutter ~~sugar tong cast splint and it is okay to increase has activity as tolerated. He will rest this~~ will return in two weeks if he is not able to return to work by then.

George A. Brown, M.D. bml

9-13-83 No show

9-14-83 Rec'd fax, doctor wrote on ankle. Has not been able to work, to work. No meds. AP.

Ok to Return to work.

He is released to return to work. He has full range of motion of the ankle and has no significant pain in the ankle at this point.

George A. Brown, M.D. bml

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P.O. Box 1149, Juneau, Alaska 99811

PHYSICIAN'S REPORT

INITIAL — Employee: Sections 1 & 2; Physician: Sections 3 & 4 ☐ PROGRESS — Physician: Sections 1 & 4

AWCB Case Number: 6.15.83 initi

SECTION 1

1. Employee's Name (Last, First, Middle Initial): JOE R Richardson
2. Insurer Claim No.:
3. Injury Date: 561, 39, 850
4. Address: SR20145C Al 99709 455-6751
City / State / Zip Code / Telephone: Insulation Service
5. Sex: ☑ Male ☐ Female
6. Social Security Number:
7. Birthdate: 3, 2, 59
8. Employer: Insulation Abc.
9. Insurer: Northern Adjusters
10. Address: PO Box 7726
City: Tulsa State: OK Zip Code: 74105 Telephone:
11. Address: 2609 Arctic Blvd.
City: Anchorage State: AK Zip Code: 99503 Telephone:

SECTION 2

12. Date Last Worked: July, 13, 83
13. Was Body Part Injured Before? ☐ No ☑ Yes If yes, when and describe: June 13 Same injury
14. Describe Injury and Tell How It Happened: Twisted Ankel
15. Have You Seen Any Other Doctor for this Injury? ☐ No ☑ Yes If yes, list name and address: Kelly
16. Hospitalized as Inpatient? Name of Hospital ☐ No ☐ Yes

SECTION 3

17. YOUR First Treatment Date: 7, 15, 83
18. Describe Complaints: See attached
19. Fully Describe Findings on First Examination (Specify Right or Left): See attached
20. Diagnosis: See attached
21. X-Rays? ☒ No ☐ Yes X-Ray Diagnosis:
22. Is Condition Work Related? ☐ No (Explain): ☒ Yes ☐ Undetermined (Explain):
23. Describe Treatment (and/or Attach Chart Notes): See attached

SECTION 4

24. Treatment Date(s) Since Last Report: 7, 15, 83
25. Next Treatment Date: 2 weeks
26. Estimate Length of Further Treatment: Unknown ___ Days ___ Weeks ___ Months
27. Date Discharged From Treatment: / /
28. Medically Stationary ☒ No ☐ Yes
29. Will Vocational Rehabilitation Be Needed? ☐ No ☐ Yes ☒ Undetermined
30. Will Injury Result In Permanent Impairment? ☐ No ☐ Yes ☑ Undetermined
31. Impairment Rating:
32. Factors on Which Rating Is Based:
33. Released for work ☒ No ☐ Yes — Estimate Length of Disability: ☐ 1-3 Days ☐ 4-14 Days ☒ 15-21 Days ☐ 22-28 Days ☐ More: ___ Weeks ___ Months; ☐ Regular Work Date: / / ☐ Modified Work Date: / / Give Limitations:
34. Remarks (and/or Attach Chart Notes): See attached

RECEIVED
AUG .. 1983
WC ANCH.

35. If Case Referred to Another Physician, Name and Address: N/A
36. Medical Aid Account No
37. Physician's Name and Degree: GEORGE A. BROWN, M.D. PROFESSIONAL CORPORATION 1919 Lathrop Suite No. 124 Drawer No. 9 Fairbanks, Alaska 99701 (907) 452-8275
38. Physician's Signature: George A. Brown
39. Report Date: 7, 28, 83
40. Address / City / State / Zip Code
41. Telephone

Form 07-6102 (Rev. 12/81)

SEE INSTRUCTIONS ON BACK

Joe L. Richardson

7-15-83 First injured lt. ankle twisting it on a rock at work 6.15.83. Reinjured ankle 7.8.83 twisting it walking on a plywood floor that had a hole in it. Seen Dr Kelly. No meds NKA. LK

He injured his ankle twisting it on a rock at work on 6-15-83. Casted for approximately three weeks and then returned to work when the cast was removed. Reinjured the ankle on 7-5-83.

EXAM: He has some swelling laterally although clinically the ankle is stable both medially and laterally to stress testing. One can palpate the lateral ligament. He states that the x-rays were within normal limits. The x-rays are not here for review today. He has full dorsiflexion, plantarflexion of the ankle. He was placed in a Cutter sugar tong cast splint and it is okay to increase has activity as tolerated. He will test this. He will return in two weeks if he is not able to return to work by then.

George A. Brown, M.D. bml

RECEIVED

no benefit paid
salary paid by employer
reporting obligation applies -
$340 penalty paid

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

AWCB JUNEAU NOV 09 1984
DATE [redacted]

18490 A.T.

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

ACCORDING TO AS 23.30.155(A),(C), AND (E), COMPENSATION PAYMENTS MUST BE MADE WITHIN 7 DAYS AFTER PAYMENT IS DUE UNLESS TIMELY CONTROVERTED OR LATE PAYMENT RESULTED FROM CONDITIONS BEYOND YOUR CONTROL.

YOUR RECENT COMPENSATION REPORT FOR THE CASE CAPTIONED BELOW INDICATES THE PAYMENT YOU MADE 09/06/84, WAS LATER THAN 7 DAYS AFTER DUE.

IF YOU DISPUTE THIS DETERMINATION, PLEASE ADVISE THE REASONS WHY THE PENALTY SHOULD BE EXCUSED. IF YOU DO NOT DISPUTE IT, PLEASE PAY THE INJURED WORKER 20% OF EACH LATE INSTALLMENT OF COMPENSATION AND FILE A COMPENSATION REPORT SHOWING THAT PAYMENT.

EMPLOYEE: BONNER, DAVID
P.O. BOX 479

SITKA AK 99835

EMPLOYER: SHELDON JACKSON COLLEGE
LINCOLN & JEFF DAVIS STS
BOX 479
SITKA AK 99835

INJURY DATE: 08/03/84
AWCB CASE NO: ~~417373~~
REF YOUR CLAIM 59-018490

VERY TRULY YOURS,

PATRICIA A. SHIRA
WORKERS COMPENSATION OFFICER.

FORM NO. 6104P

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY.
READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ASKA DEPARTMENT OF LABOR
aska Workers' Compensation Board
x 1149, Juneau, Alaska 99802

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1984 & AFTER)

AWCB Case Number: 417312

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
Bonner David B	59-018490	08 / 03 / 84

4. Address	5.a. ☐ Single ☐ Married	5.b. No. of Dependents	6. Social Security Number
836 Hillcrest Dr.			421 - 42 - 0951

City	State	Zip	Telephone	AWCB Juneau	7. Birthdate
Sitka.	AK	99835	747-8959	OCT 31 1984	05 / 24 / 33

8. Employer	9. Insurer/Adjusting Company
Sheldon College	Industrial Indemnity Insurance Co.
10. Address	**11. Address**
Box 479	P.O. Box 307
City: Sitka, State: AK, Zip: 99835, Telephone:	City: Anchorage, State: Ak, Zip: 99510, Telephone: 561-6000

COMPENSATION RATE (Complete for initial payment or rate change)

12. METHOD
- ☐ 1. Awaiting gross earnings documents
- ☐ 2. Two years gross earnings. Documents received: / / (Date)
- ☐ 3. Nature of work/work history
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.
- ☐ 6. Offset: Social Security (#42) or §155(j) (#33)

13. If method 3, 4, or 5, how did you figure gross weekly earnings?

☐ 14. Board and room included. Explain how you figured it.

15. MAIL

	b. Gross Earnings	Gross Weekly Earnings	Alaska Weekly Rate*	Alaska Max. or Min.
☑ a. Alaska TTD, PTD, death or scheduled PPD	$	÷ 100 weeks = $	− Tax & FICA × 80% = $	$ 110.00
☐ c. Alaska unscheduled PPD or TPD	d. Alaska Wk. TTD Rate $	Wk. Earning Capacity (− Tax & FICA × 80% = $)	Alaska Weekly Rate =$	Alaska Max. or Min. $
☐ e. Out-of-state TTD, TPD, PPD, PTD or death	f. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio % × $	Alaska Weekly Rate = $

g. State or Country h. Date Left / / Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (§41)

16. ☑ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☑ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☑ i. OTHER (Explain) Wage continuation

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
9/6/84	TTD	8/10/84	8/14/84	0-5	$ 110.00	$ 78.60
					$	$
					$	$
					$	$
					$	$
					$	$
	(If additional space is needed, use chart on reverse.)				TOTAL	$ 78.60

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began	8 17 84	22. a. Employee Attorney Fees $	b. Late Report Penalties $
b. First Payment Date	9 16 84	c. Employer Attorney Fees $	d. Medical $
21. Date Disability Ended	8 14 84	e. Second Injury Fund $ ☐ Check to SIF Attached	f. Rehabilitation $
			g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☑ Returned to Work 8 15 84 (Date) ☐ New Job ☑ At Same Job
Occupation
Weekly Pay Rate $

☑ Released for Work Date 8 15 84
☑ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6106)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: Claimant worked from DOI 8/3/84 thru 8/6/84. Claimant received sick pay for time he was off.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Alicia Thurman, Claims Rep.	Alicia Thurman	10 23 84

37. Address (If different from No. 11) City State Zip Telephone

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 11/07/

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 28 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT FOR A PAYMENT MADE 09/06/84 WAS FILED 25 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $340.

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: BONNER, DAVID
P.O. BOX 479

SITKA AK 99835

EMPLOYER: SHELDON JACKSON COLLEGE
LINCOLN & JEFF DAVIS STS
BOX 479
SITKA AK 99835

INJURY DATE: 08/03/84
AWCB CASE NO: ~~417379~~
REF YOUR CLAIM 59-018490

VERY TRULY YOURS,

ALASKA WORKERS COMPENSATION DIVISION
SECOND INJURY FUND

FORM NO. 6104R

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

David Bonner Employee,

vs.

Sheldon Jackson College Employer,

and

Industrial Indemnity Co. Insurers, Defendants.

AFFIDAVIT

Case No. 417373

State of Alaska)
) ss.
First Judicial District)

Elaine VanderSande, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 09|06|84 was postmarked 10|29|84 and received 10|31|84 in Juneau, Alaska.

Elaine VanderSande

Elaine VanderSande

Subscribed and sworn to before me this 14th day of November 1984, in Juneau, Alaska.

Patricia A. Rivera

Notary Public for Alaska

My commission expires 10-21-87.

07-G6LH

Benefit Paid #15.12 - Penalty - 390

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE ~~09/13/84~~
9/18/84

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 30 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT FOR A PAYMENT MADE WAS FILED 30 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $390.

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: MOORE, ANTHONY G.
S.P. BOX 40284-C

FAIRBANKS AK 99701

EMPLOYER: WRIGHT SCHUCHART HARBOR
P O BOX 56991

NORTH POLE AK 99705

INJURY DATE: 06/07/84
ANCB CASE NO: 411477
REF YOUR CLAIM 59[illegible]110

VERY TRULY YOURS,

~~J. PAUL LOHSE~~, ADMINISTRATOR
SECOND INJURY FUND
Elaine VanderSande, dc

FORM NO. 6104P

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY.
READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99802

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1984 & AFTER)

AWCB Case Number: 411477

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
Moore, Anthony G	59-018110	06 / 07 / 84

4. Address	5. a. ☐ Single ☐ Married	5. b. No. of Dependents	6. Social Security Number
S.R. 50284-C 4MI-Steese			310 - 52 - 2662

City	State	Zip	Telephone	7. Birthdate
Fairbanks,	Ak	99.01	452-5760	12 / 10 / 47

8. Employer	9. Insurer/Adjusting Company
Wright Schuchart Inc.	Industrial Indemnity Insurance Co.

10. Address	11. Address
P.O. Box 3764	P.O. Box 307

City	State	Zip	Telephone	City	State	Zip	Telephone
Seattle,	WA	98104		Anchorage,	Alaska	99510	561-6000

COMPENSATION RATE (Complete for initial payment or rate change)

12. METHODS

- ☑ 1. Awaiting gross earnings documents
- ☐ 2. Two years gross earnings — Documents received: / / (Date)
- ☐ 3. Nature of work/work history
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.
- ☐ 6. Offset: Social Security (#42) or §155(j) (#33)

13. If method 3, 4, or 5, how did you figure gross weekly earnings?

☐ 14. Board and room included. Explain how you figured it.

15. RATE

☑ a. Alaska TTD, PTD, death or scheduled PPD	b. Gross Earnings $	Gross Weekly Earnings + 100 weeks = $	Alaska Weekly Rate* − Tax & FICA x 80% = $	Alaska Max. or Min. $ 110.00
☐ c. Alaska unscheduled PPD or TPD	d. Alaska Wk. TTD Rate $	Wk. Earning Capacity − (− Tax & FICA x 80% = $)	Alaska Weekly Rate =$	Alaska Max. or Min. $
☐ e. Out-of-state TTD, TPD, PPD, PTD or death	f. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage − $	State Ratio % x $	Alaska Weekly Rate = $ / State Weekly Rate

g. State or Country — h. Date Left / / — I. Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (#41)

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☒ i. OTHER (Explain) Late Report P.n.

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
7-2-84	TTD	6-12-84	6-12-84	0- 1	$ 110.00	$ 15.72
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 15.72

18. Impairment Rating: ____ % of _____ ; ____ % of _____ ; ____ % of _____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began	6/9/84	22. a. Employee Attorney Fees $	b. Late Report Penalties $ 390.00
b. First Payment Date	7/2/84	c. Employer Attorney Fees $	d. Medical $ 245.00
21. Date Disability Ended	6/12/84	e. Second Injury Fund $ .94	f. Rehabilitation $
		☐ $ N/A Check to SIF Attached	g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☑ Returned to Work 6/13/84 (Date)	24. ☑ Released for Work Date 6/13/84	25. ☐ Moved from Alaska	26. ☐ Compromise and Release
☐ At New Job ☑ At Same Job		27. ☐ Returned to Alaska	28. ☐ Controversion (Attach 07-6105)
Occupation _____	☑ Regular Work	29. ☐ Recomputation	30. ☐ Board Order
Weekly Pay Rate $	☐ Modified Work	31. ☐ Other	32. ☐ Lack Recent Medical Report

33. Remarks:
Claimant has still not sent in W2 as of this date

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Alicia Thurman, Claims Rep.	Alicia Thurman	10 / 10 / 84

37. Address (If different from No. 11)	City	State	Zip	Telephone

INDUSTRIAL INDEMNITY
A CRUM & FORSTER INSURANCE COMPANY

payment instruction worksheet

ROUTE TO
1) Mary 2) 3)

TYPE OF PAYMENT

☐ IND. ☐ MED. ☐ EXP. _____
☐ PARTIAL ☐ SUPPLEMENTAL (PAYMENT ON CLOSED CLAIM)
☐ SALVAGE EXP. ☐ SUBRO EXP.
☐ ADVANCED PAYMENT ☐ DROP CHECK
☐ FINAL (KEEP CLAIM OPEN) ☐ FINAL (CLOSE CLAIM)

FILE DESTRUCTION DATE (M/Y)

CLAIM NUMBER ▶ | FEATURE # 1 | AMOUNT ▶ $ 390.00

ISSUE TO:
SIF
PAID
OCT 11 1984
Voucher # 2483338

PAYMENT DISTRIBUTION
FEATURE NO. _____ $ _____
FEATURE NO. _____ $ _____

IRS NUMBER

MAIL TO:

REASON FOR PAYMENT:
Late Report Pen.
Anthony G. Moore

TYPE OF PAYMENT

☐ IND. ☐ MED. ☐ EXP. _____
☐ PARTIAL ☐ SUPPLEMENTAL (PAYMENT ON CLOSED CLAIM)
☐ SALVAGE EXP. ☐ SUBRO EXP.
☐ ADVANCED PAYMENT ☐ DROP CHECK
☐ FINAL (KEEP CLAIM OPEN) ☐ FINAL (CLOSE CLAIM)

FILE DESTRUCTION DATE (M/Y)

CLAIM NUMBER ▶ | FEATURE | AMOUNT ▶ $

ISSUE TO:

PAYMENT DISTRIBUTION
FEATURE NO. _____ $ _____
FEATURE NO. _____ $ _____

IRS NUMBER

MAIL TO:

REASON FOR PAYMENT:

SPECIAL INSTRUCTIONS
Copy all to CAS
Ref SIF

REQUESTED BY	DATE	APPROVED BY	DATE	FILE DESTRUCTION DATE (M/Y)
CAT Wolfe		OBS	10/10/84	

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Anthony G. Moore Employee,

vs.

Wright Schuchart Harbor Employer,

and

Industrial Indemnity Co. Insurers, Defendants.

AFFIDAVIT

Case No. AWCB 411477

State of Alaska)
) ss.
First Judicial District)

Elaine VanderSande, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 7/2/84 was postmarked 8/29/84 and received 8/31/84 in Juneau, Alaska.

Elaine VanderSande

Subscribed and sworn to before me this 19th day of September 1984, in Juneau, Alaska.

Notary Public for Alaska

My commission expires 10-21-87.

07-GGLH

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY.
READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99802

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1984 & AFTER)

AWCB Case Number: 411 407

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
Moore, Anthony G.	59-018110	6 / 7 / 84

4. Address	5. a. ☐ Single ☐ Married	5. b. No. of Dependents	6. Social Security Number
S.R. 40284-C			- -

City	State	Telephone	7. Birthdate
Fairbanks,	Ak	99701	/ /

AWCB Received AUG 31 1984

8. Employer	9. Insurer/Adjusting Company
Wright Schuchart Inc.	

10. Address	11. Address
	[illegible] INDEMNITY CO P. O. BOX 307 ANCHORAGE, AK. 99510

City	State	Zip	Telephone	City	State	Zip	Telephone

COMPENSATION RATE (Complete for initial payment or rate change)

12. METHODS

- ☑ 1. Awaiting gross earnings documents
- ☐ 2. Two years gross earnings — Documents received: / / (Date)
- ☐ 3. Nature of work/work history
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.
- ☐ 6. Offset: Social Security (#42) or §155(j) (#33)

13. If method 3, 4, or 5, how did you figure gross weekly earnings? _____

☐ 14. Board and room included. Explain how you figured it. _____

15. RATE

	Gross Weekly Earnings			
☑ a. Alaska TTD, PTD, death or scheduled PPD	b. Gross Earnings $	÷ 100 weeks = $	- Tax & FICA × 80% = $	Alaska Weekly Rate* $ 110.00
☐ c. Alaska unscheduled PPD or TPD	d. Alaska Wk. TTD Rate $	- (Wk. Earning Capacity	- Tax & FICA × 80% = $) =	Alaska Weekly Rate $ — Alaska Max. or Min. $
☐ e. Out-of-state TTD, TPD, PPD, PTD or death	f. State Avg. Wk. Wage $	÷ Alaska Avg. Wk. Wage $ =	State Ratio % ×	Alaska Weekly Rate $ = State Weekly Rate $

g. State or Country _____ h. Date Left / / i. Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (#41)

16. ☑ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
7/2/84	TTD	6/12/84	6/12/84	0 1	$ 110.00	$ 15.72
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 15.72

18. Impairment Rating: ____ % of _____ ; ____ % of _____ ; ____ % of _____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? _____

20. a. Date Disability Began	6 19 84	22. a. Employee Attorney Fees $	b. Late Report Penalties $
b. First Payment Date	7 12 84	c. Employer Attorney Fees $	d. Medical $ 245
21. Date Disability Ended	6 12 84	e. Second Injury Fund $ .94	f. Rehabilitation $
		☐ $ Check to SIF Attached	g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☑ Returned to Work 6 13 84 (Date)	24. ☑ Released for Work Date 6 13 84	25. ☐ Moved from Alaska	26. ☐ Compromise and Release
☐ At New Job ☑ At Same Job		27. ☐ Returned to Alaska	28. ☐ Controversion (Attach 07-6105)
Occupation _____	☑ Regular Work	29. ☐ Recomputation	30. ☐ Board Order
Weekly Pay Rate $	☐ Modified Work	31. ☐ Other	32. ☐ Lack Recent Medical Report

33. Remarks:

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Alicia Thurman Claims Rep.	Alicia Thurman	8 23 84

37. Address (If different from No. 11)	City	State	Zip	Telephone

Form 07-6101

DELIVER TO:

11/14/84

- ☐ I.I.
- ☐ I.U.I
- ☐ CENTRAL DIVISION
- ☐ MORRISTOWN
- ☐ WDP
- ☑

ATTENTION:

NAME Cathy Smith

ACTION REQUESTED:

- ☐ INFORMATION
- ☐ COMMENTS
- ☐ FOR FILE
- ☐ APPROVAL
- ☐ SIGNATURE
- ☐ AN APPOINTMENT
- ☐ PLEASE HANDLE
- ☐ PLEASE RETURN
- ☐ OTHER

MESSAGES AND/OR DESCRIPTIONS:

oversight on part of tech - benefit 31.44 late penalty $440 - equitable

FROM NT DATE

INTER-OFFICE ROUTING

INDUSTRIAL INDEMNITY
A CRUM & FORSTER INSURANCE COMPANY

payment instruction worksheet

ROUTE TO
1) Mary 2) 3)

TYPE OF PAYMENT
- [x] IND.
- [ ] MED.
- [ ] EXP.
- [ ] PARTIAL
- [ ] SUPPLEMENTAL (PAYMENT ON CLOSED CLAIM)
- [ ] SALVAGE EXP.
- [ ] SUBRO EXP.
- [ ] ADVANCED PAYMENT
- [ ] DROP CHECK
- [ ] FINAL (KEEP CLAIM OPEN)
- [ ] FINAL (CLOSE CLAIM)

FILE DESTRUCTION DATE (M/Y)

CLAIM NUMBER ▶ | FEATURE 1 | AMOUNT ▶ $ 440.00

ISSUE TO:
SIF

PAYMENT DISTRIBUTION
FEATURE NO. _____ $ _____
FEATURE NO. _____ $ _____

IRS NUMBER

MAIL TO:

REASON FOR PAYMENT:
late penalty payment

TYPE OF PAYMENT
- [ ] IND.
- [ ] MED.
- [ ] EXP.
- [ ] PARTIAL
- [ ] SUPPLEMENTAL (PAYMENT ON CLOSED CLAIM)
- [ ] SALVAGE EXP.
- [ ] SUBRO EXP.
- [ ] ADVANCED PAYMENT
- [ ] DROP CHECK
- [ ] FINAL (KEEP CLAIM OPEN)
- [ ] FINAL (CLOSE CLAIM)

FILE DESTRUCTION DATE (M/Y)

CLAIM NUMBER ▶ | FEATURE | AMOUNT ▶ $

ISSUE TO:

PAYMENT DISTRIBUTION
FEATURE NO. _____ $ _____
FEATURE NO. _____ $ _____

IRS NUMBER

MAIL TO:

REASON FOR PAYMENT:

SPECIAL INSTRUCTIONS
1) pay SIF
2) make copies of all paperwork from State to CSB

REQUESTED BY	DATE	APPROVED BY	DATE	FILE DESTRUCTION DATE (M/Y)
[illegible]	11/9/84	CSB	11/13/84	

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 10/15/84

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 28 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT FOR A PAYMENT MADE 06/27/84 WAS FILED 35 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $440.

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: 'PUTNAM, EDITH E.'
PALMER ARMS B-17

PALMER AK 99645

EMPLOYER: VALLEY HOTEL
P.O. BOX 822

PALMER AK 99645

INJURY DATE: 06/01/84
AWCB CASE NO: 411176
REF YOUR CLAIM 59-018086

VERY TRULY YOURS,

ALASKA WORKERS COMPENSATION DIVISION
SECOND INJURY FUND

FORM NO. 6104R

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Putnam, Edith, E. Employee,

vs.

(Palmer) Valley Hotel Employer,

and

Industrial Indemnity Insurers, Defendants.

AFFIDAVIT

Case No. 411186

State of Alaska)
) ss.
First Judicial District)

Elaine VanderSande, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 6/27/84 was postmarked 8/29/84 and received 8/31/84 in Juneau, Alaska.

Elaine VanderSande

Subscribed and sworn to before me this 29th day of October 1984, in Juneau, Alaska.

Notary Public for Alaska

My commission expires 6-21-87.

07-G6LH

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY.
READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99802

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1984 & AFTER)

AWCB Case Number: 411186 ✓

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
Putnam, Edith E	59-018086	6 / 1 / 84

4. Address	5. a. ☐ Single ☐ Married	5. b. No. of Dependents	6. Social Security Number
Palmer Arms B 17			- -

City	State	Zip	Telephone	7. Birthdate
Palmer, Alaska 99645				/ /

RECEIVED AUG 31 1984

8. Employer	9. Insurer/Adjusting Company
Valley Hotel	
10. Address	11. Address INDUSTRIAL INDEMNITY CO. P. O. BOX 307
City / State / Zip / Telephone	City / State / Zip / Telephone

COMPENSATION RATE (Complete for initial payment or rate change)

METHODS

12. ☑ 1. Awaiting gross earnings documents
☐ 2. Two years gross earnings
Documents received: / / (Date)
☐ 3. Nature of work/work history
☐ 4. Minor or apprentice
☐ 5. Volunteer policeman, etc.
☐ 6. Offset: Social Security (#42) or 5155(j) (#33)

13. If method 3, 4, or 5, how did you figure gross weekly earnings?

☐ 14. Board and room included. Explain how you figured it.

RATE

15. ☑ a. Alaska TTD, PTD, death or scheduled PPD
b. Gross Earnings $ ÷ 100 weeks = $ Gross Weekly Earnings − Tax & FICA x 80% = $ Alaska Weekly Rate*
Alaska Max. or Min. $ 110.00

☐ c. Alaska unscheduled PPD or TPD
d. Alaska Wk. TTD Rate $ − (Wk. Earning Capacity − Tax & FICA x 80% = $) * Alaska Weekly Rate = $
Alaska Max. or Min. $

☐ e. Out-of-state TTD, TPD, PPD, PTD or death
f. State Avg. Wk. Wage $ ÷ Alaska Avg. Wk. Wage $ = State Ratio % x Alaska Weekly Rate $ = State Weekly Rate $

g. State or Country h. Date Left / / i. Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (#41)

16. ☑ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☑ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
6/27/84	TTD	6/5/84	6/6/84	0 2	$ 110.00	$ 31.44
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 31.44

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 6/2/84
b. First Payment Date 6/27/84
21. Date Disability Ended 6/6/84

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ ____
e. Second Injury Fund $ ____ f. Rehabilitation $ ____
☐ $ ____ Check to SIF Attached g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☑ Returned to Work 6/7/84 (Date)
☐ At New Job ☑ At Same Job
Occupation ____
Weekly Pay Rate $ ____

24. ☑ Released for Work Date 6/7/84
☑ Regular Work
☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks:

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Alicia Thurman Claims Rep.	Alicia Thurman	8 / 23 / 84

37. Address (If different from No. 11)	City	State	Zip	Telephone

Form 07-6104

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 5/10/84

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 14 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT WAS FILED 2 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $120.00

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: EBERSOLE, ROBERT D.
3506 WYOMING

ANCHORAGE AK 99503
EMPLOYER: SOUTHCENTRAL CONSTRUCTION & DEVE
8740 HARTZELL RD

ANCHORAGE AK 99507
INJURY DATE: 02/20/84
AWCB CASE NO: 402550
REF YOUR CLAIM 59-017771

VERY TRULY YOURS,

J. PAUL HOUSE, ADMINISTRATOR
SECOND INJURY FUND

FORM NO. 6104R

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Robert D. Ebersole
Employee,

vs.

Southcentral Construction + Dev.
Employer

and

Industrial Indemnity Co.
Insurer,
Defendants.

AFFIDAVIT

Case No. 402550

State of Alaska)
) ss.
First Judicial District)

J. Paul House, being first duly sworn, says:

1. I am an employee of the State of Alaska, Divisi n of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 4-2-84 was postmarked 4-18-84 and received 4-20-84 in Juneau, AK.

J. Paul House
J. Paul House

Subscribed and sworn to before me this 10th day of May, 1984, in Juneau, Alaska.

Elaine Vandenbrande
Notary Public for Alaska
My commission expires 6/24/87.

07-G6LH

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY.
RE[illegible] IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box [illegible], Juneau, Alaska 99802

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1984 & AFTER)

AWCB Case Number: 4102550

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
EBERSOLE, ROBERT	59-017771	02 / 20 / 84

4. Address	5. a ☐ Single ☐ Married	5. b. No. of Dependents	6. Social Security Number
2426 W. NORTHERN LIGHTS			- -

City	State	Zip	Telephone
ANCHORAGE,	AK	99503	

AWCB BUREAU APR 20 1984 4/18/84 P

7. Birthdate: / /

8. Employer	9. Insurer/Adjusting Company
SOUTHCENTRAL CONSTRUCTION & DELV.	INDUSTRIAL INDEMNITY

10. Address	11. Address
	P.O. BOX 307

City	State	Zip	Telephone
	ANCHORAGE	AK 99510	561-6000

COMPENSATION RATE (Complete for initial payment or rate change)

12. METHODS
- ☒ 1. Awaiting gross earnings documents
- ☐ 2. Two years gross earnings — Documents received: / / (Date)
- ☐ 3. Nature of work/work history
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.
- ☐ 6. Citizen Social Security (642) or §155(j) (633)

13. If method 3, 4, or 5, how did you figure gross weekly earnings?

☐ 16. Board and room included. Explain how you figured it.

15. RATE

	b. Gross Earnings	Gross Weekly Earnings	Alaska Weekly Rate	Alaska Max. or Min.
☐ a. Alaska TTD, PTD, death or scheduled PPD	$	÷ 100 weeks = $	- Tax & FICA x 80% = $	$ 110.00
☐ c. Alaska unscheduled PPD or TPD	d. Alaska Wk. TTD Rate $	Wk. Earning Capacity - (- Tax & FICA x 80% = $)	Alaska Weekly Rate =$	Alaska Max. or Min.
☐ e. Out of state TTD, TPD, PPD, PTD or death	f. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $ =	State Ratio % x $	Alaska Weekly Rate = $

g. State or Country — h. Date Left / / — i. Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (641)

18. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☒ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
4/2/84	TTD	2/20/84	3/25/84	5 6/7	$ 110.00	$ 534.32
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 534.32

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began	2/20/84	22. a. Employee Attorney Fees $	b. Late Report Penalties $
b. First Payment Date	3/23/84	c. Employer Attorney Fees $	d. Medical $ 223.00
21. Date Disability Ended	3/25/84	e. Second Injury Fund ☐ $	f. Rehabilitation $
		Check to SIF Attached	g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work / / (Date) ☐ At New Job ☐ At Same Job
Occupation ____ Weekly Pay Rate $ ____

24. ☒ Released for Work Date 3/26/84
☐ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: NOTE: 4/3/84 RECEIVED DR's REPORT INDICATING RELEASED FOR WORK 2/26/84. OVERPAYMENT IN THE AMOUNT OF $125.72.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
DEBORAH S. DOLAN: CLAIMS REP.	Deborah S. Dolan	4/18/84

37. Address (if different from No. 11) ____ City ____ State ____ Zip ____ Telephone ____

Form 07-6104 — EXPLANATIONS AND INSTRUCTIONS ON BACK

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 11/07/8

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 28 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT FOR A PAYMENT MADE 09/06/84 WAS FILED 25 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $340.

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: BONNER, DAVID
P.O. BOX 479

SITKA AK 99835

EMPLOYER: SHELDON JACKSON COLLEGE
LINCOLN & JEFF DAVIS STS
BOX 479
SITKA AK 99835

INJURY DATE: 09/03/84
AWCB CASE NO: ~~417379~~
REF YOUR CLAIM 59-018490

VERY TRULY YOURS,

ALASKA WORKERS COMPENSATION DIVISION
SECOND INJURY FUND

FORM NO. 6104R

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

LASKA DEPARTMENT OF LABOR
aska Workers' Compensation Board
x 149, Juneau, Alaska 99802

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1984 & AFTER)

AWCB Case Number: 417312

1. Employee's Name (Last, First, Middle Initial): Bonner David B
2. Insurer Claim Number: 59-018490
3. Injury Date: 08 / 03 / 84
4. Address: 836 Hillcrest Dr.
5. a. ☐ Single ☐ Married 5. b. No. of Dependents:
6. Social Security Number: 421 - 42 - 0951
City: Sitka State: AK Zip: 99835 Telephone: 747-8959
AWCB Juneau: OCT 31 1984
7. Birthdate: 05 / 24 / 33
8. Employer: Sheldon College
9. Insurer/Adjusting Company: Industrial Indemnity Insurance Co.
10. Address: Box 479
11. Address: P.O. Box 307
City: Sitka State: AK Zip: 99835 Telephone:
City: Anchorage State: Ak Zip: 99510 Telephone: 561-6000

COMPENSATION RATE (Complete for initial payment or rate change)

METHOD

12. ☐ 1. Awaiting gross earnings documents
☐ 2. Two years gross earnings
Documents received: / / (Date)
☐ 3. Nature of work/work history
☐ 4. Minor or apprentice
☐ 5. Volunteer policeman, etc.
☐ 6. Offset: Social Security (#42) or §155(j) (#33)

13. If method 3, 4, or 5, how did you figure gross weekly earnings?

☐ 14. Board and room included. Explain how you figured it.

RATE

15. ☑ a. Alaska TTD, PTD, death or scheduled PPD	b. Gross Earnings $	Gross Weekly Earnings ÷100 weeks = $	Alaska Weekly Rate* − Tax & FICA x 80% = $	Alaska Max. or Min. $ 110.00
☐ c. Alaska unscheduled PPD or TPD	d. Alaska Wk. TTD Rate $	Wk. Earning Capacity − (− Tax & FICA x 80% = $)	Alaska Weekly Rate =$	Alaska Max. or Min. $
☐ e. Out-of-state TTD, TPD, PPD, PTD or death	f. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage + $ =	State Ratio % x	Alaska Weekly Rate $ =	State Weekly Rate $

g. State or Country h. Date Left / / i. Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (#41)

16. ☑ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain) wage continuation

MAIL

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
9/6/84	TTD	8/10/84	8/14/84	0-5	$ 110.00	$ 78.60
					$	$
					$	$
					$	$
					$	$
					$	$
(If additional space is needed, use chart on reverse.)					TOTAL	$ 78.60

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____
19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began: 8 / 7 / 84
b. First Payment Date: 9 / 10 / 84
21. Date Disability Ended: 8 / 14 / 84

22. a. Employee Attorney Fees $ b. Late Report Penalties $ 340.00
c. Employer Attorney Fees $ d. Medical $
e. Second Injury Fund $ f. Rehabilitation $
☐ $ Check to SIF Attached g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☑ Returned to Work 8 / 15 / 84 (Date)
☐ At New Job ☑ At Same Job
Occupation
Weekly Pay Rate $

24. ☑ Released for Work
Date 8 / 15 / 84
☑ Regular Work
☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: Claimant worked from DOI 8/3/84 thru 8/6/84. Claimant received sick pay for time he was off.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print): Alicia Thurman, Claims Rep.
35. Signature: Alicia Thurman
36. Date: 10 / 23 / 84
37. Address (If different from No. 11) City State Zip Telephone

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

David Bonner Employee,

vs.

Sheldon Jackson College Employer,

and

Industrial Indemnity Co. Insurers, Defendants.

AFFIDAVIT

Case No. 417375

State of Alaska)
) ss.
First Judicial District)

Elaine VanderSande, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 09/06/84 was postmarked 10/29/84 and received 10/31/84 in Juneau, Alaska.

Elaine VanderSande

Elaine VanderSande

Subscribed and sworn to before me this 14th day of November 1984, in Juneau, Alaska.

Patricia A Rhea

Notary Public for Alaska

My commission expires 10-21-87.

07-G6LH

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 4/11/84

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 14 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT WAS FILED 6 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF ~~$100.00~~ $160.00 (1-1-84 amendment applies)

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: KING, RICHARD M.
P.O. BOX 143

FAIRBANKS AK 99707

EMPLOYER: ALASKA RENTAL & SALES
P.O. BOX 40056
INT'L AIRPORT GATE 5
FAIRBANKS AK 99707

INJURY DATE: 09/22/82
AWCB CASE NO: 220489
REF YOUR CLAIM 59-C-016037 Caa

VERY TRULY YOURS,

J. Paul House

J. PAUL HOUSE, ADMINISTRATOR
SECOND INJURY FUND

FORM NO. 6104R

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Richard M. King
Employee,

vs.

Alaska Rental + Sales
Employer

and

Industrial Indemnity
Insurer,
Defendants.

AFFIDAVIT

Case No. 220448

State of Alaska)
) ss.
First Judicial District)

J. Paul House, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 2-28-84 was postmarked 3-19-84 and received 3-21-84 in Juneau, AK.

J. Paul House

Subscribed and sworn to before me this 11th day of April, 1984, in Juneau, Alaska.

Patricia A. Shea
Notary Public for Alaska
My commission expires 6-21-87

07-G6LH

EMPLOYEE: KEEP [illegible] FOR YOUR RECORDS. [illegible] INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT [illegible] RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 220488

1. Employee's Name (Last, First, Middle Initial): KING RICHARD
2. Insurer Claim Number: 59-016037
3. Injury Date: 09 / 30 / 82
4. Address: P.O. BOX 143
City: FAIRBANKS, State: AK. Zip: 99707 Telephone:
AWCB JUNEAU MAR 21 1984 3/19/84P
5. Social Security Number: – –
6. Birthdate: / /
7. Employer: ALASKA RENTAL & SALES
8. Insurer/Adjusting Company: INDUSTRIAL INDEMNITY
9. Address:
City: State: Zip: Telephone:
10. Address: P.O. BOX 307
City: ANCHORAGE, State: AK. Zip: 99510 Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
☐ 1. Awaiting gross wages documents
☐ 2. Highest of three years, 19 ____ Documents received: / / Date
☐ 3. Same or similar wages
☐ 4. Minor or apprentice
☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $ 175.64

15. HOW RATE WAS FIGURED

	a. Gross Wages	Employee Avg. Wk. Wage	Alaska Weekly Rate	Alaska Max. or Min.
☑ a. Alaska TTD, PTD, death or scheduled PPD	$	÷ 52 weeks = $	X 66 2/3% = $	$
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity –$	Difference =$	Alaska Weekly Rate X 66 2/3% = $
☐ c. Other state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate X $ = $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☑ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
	TTD	10-1-82	10-10-82	1 3	$ 175.64	$ 250.91
	TTD	10-16-82	2-18-83	18	$ 175.64	$ 3161.52
	TTD	2-18-83	4-28-83	9 6	$ 103.10	$ 1016.28
	TTD	4-29-83	7-17-83	11 3	$ 175.64	$ 2001.31
11-23-83	TTD	7-18-83	11-27-83	19	$ 175.64	$ 3337.16
2-28-84	TTD	1-2-84	2-24-84	4 1	$ 173.64	$ 727.65
					TOTAL	$ 10500.83

(If additional space is needed, use chart on reverse.)

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 10/ 1/82
b. First Payment Date 10/ 20/ 82
c. Date Disability Ended 2/24/84

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ 7189.90
e. Second Injury Fund $ ____ f. Rehabilitation $ 1357.85
☐ $ Check to SIF Attached g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work ____ Date ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____
24. ☑ Released for Work Date 2/25/84
☑ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: Employee overpaid $89.99 for above period.
1-27 → 2-27
notification of release obtained 3-12-84

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print): CATHY SMITH CLAIMS SUPERVISOR
35. Signature: Cathy Smith
36. Date: 3 / 15 / 84
37. Address if different from No. 10: City: State: Zip: Telephone:

Form 07-6104 (Rev. 6/82) EXPLANATIONS AND INSTRUCTIONS ON BACK 4

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 6/8/84

INDUSTRIAL INDEMNITY CO
PO BOX 307

ANCHORAGE AK 99510

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 14 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT WAS FILED 3 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $150.00

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: BENSON, GARY L.
RT 1 BOX 9-A

COVE OR 97824
EMPLOYER: KONCOR
FOREST RESOURCE MGNT.
BOX 1186
KODIAK AK 99615
INJURY DATE: 05/29/83
ANCB CASE NO: 309907
REF YOUR CLAIM 59-016827

VERY TRULY YOURS,
J. PAUL HOUSE, ADMINISTRATOR
SECOND INJURY FUND

FORM NO. 6104R

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Gary L. Benson
Employee,

vs.

Forest Resource Management
Employer

and

Industrial Indemnity Co.
Insurer,
Defendants.

AFFIDAVIT

Case No. 309907

State of Alaska)
) ss.
First Judicial District)

J. Paul House, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 4-23-84 was postmarked 5-10-84 and received 5-14-84 in Juneau, AK area.

J. Paul House
Paul House

Subscribed and sworn to before me this 8th day of June, 1984, in Juneau, Alaska.

Elaine Vandenbrande
Notary Public for Alaska
My commission expires 6/24/87.

07-6136 (rev 1-12-84)

07-G6LH

EMPLOYEE: KEEP THIS REPORT FOR YOUR R... REAL IMPORTANT INFORMATIO... FOR INFORMATION ONLY. ...OUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 309407

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
BENSON GARY	59-016827	05 / 29 / 83
4. Address	5/10/84P AWCB Juneau MAY 14 1984	**5. Social Security Number**
RT. 1 BOX 8-A		- -
City: COVE, State: OREGON, Zip: 97824, Telephone:		**6. Birthdate** / /
7. Employer	**8. Insurer/Adjusting Company**	
KONCOR	INDUSTRIAL INDEMNITY	
9. Address	**10. Address**	
	P.O. BOX 307	
City: State: Zip: Telephone:	City: ANCHORAGE, State: AK. Zip: 99510 Telephone:	

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☑ 2. Highest of three years, 19 81
  Documents received: / / (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? _____

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured. _____

14. RATE $ 139.83

15. HOW RATE WAS FIGURED

☒ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $10907.06 ÷ 52 weeks = $ 209.75 (Employee Avg. Wk. Wage)		X 66 2/3% = $ 139.83 (Alaska Weekly Rate)	Alaska Max. or Min. $
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	– Earning Capacity $	= Difference $	X 66 2/3% = $ (Alaska Weekly Rate) — Alaska Max. or Min $
☐ c. Out of state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	: Alaska Avg. Wk. Wage $ = % (State Ratio)	X $ (Alaska Weekly Rate) = $	State Weekly Rate

(1) State or Country _____ (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16 ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☒ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
4/23/84	TTD	5/29/83	4/12/84	45-6	$ 139.83	$ 6412.20
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 6472.20

18. Impairment Rating: _____% of _____ _____% of _____ _____% of _____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? _____ 5/10/84

20. a. Date Disability Began 5/29/83
b. First Payment Date 6/16/83
21. Date Disability Ended 9/12/84

22. a. Employee Attorney Fees $ _____ b. Late Report Penalties $ _____
c. Employer Attorney Fees $ _____ d. Medical $ 10598-
e. Social Security $ 384.73 f. Rehabilitation $ _____
☐ $ 176.19 per _____ to SIF Attached g. Other $ -

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON PAYMENT

23. ☐ Returned to Work / / (Date) ☐ At New Job ☐ At Same Job
Occupation _____
Weekly Pay Rate $ _____

24. ☒ Released for Work Date 4/13/84
☒ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07 6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: Knowledge of RTW said via phone 5/10/84 Employee has not returned to dr. since 4/13/84, therefore presumed released to work - due to clerical

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
KAY KELL CLAIMS REPRESENTATIVE		5/10/84

37. Address (If different from No. 10) City State Zip Telephone

Form 07 6104 (Rev. 6/82) EXPLANATIONS AND INSTRUCTIONS ON BACK

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS OR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number

1. Employee's Name (Last, First, Middle Initial): Duncan, Gary
2. Insurer Claim Number: 59 C 016827
3. Injury Date: 05 / 29 / 83
4. Address: RT 1 BOX 8-A
5. Social Security Number: 541 - 70 - 0661
City: COVE, State: OREGON Zip: 97824 Telephone: (503) 568 4495
6. Birthdate: AGE / 27 /
7. Employer: KONCOR
8. Insurer/Adjusting Company: INDUSTRIAL INDEMNITY CO. OF ALASKA
9. Address: P.O.BOX 2212
City: KODIAK, State: ALASKA Zip: 99615 Telephone: 486 3985
10. Address: P.O. BOX 307
City: ANCHORAGE, State: ALASKA Zip: 99510 Telephone: 561 6000

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☑ 2. Highest of three years, 19 81
  Documents received: / / Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $ 134.83

15. HOW RATE WAS FIGURED

☒ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $	Employee Avg. Wk. Wage ÷ 52 weeks = $	Alaska Weekly Rate X 66 2/3% = $	Alaska Max. or Min. $
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity −$	Difference =$	Alaska Weekly Rate X 66 2/3% = $ / Alaska Max. or Min. $
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate X $ / State Weekly Rate = $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☑ i. OTHER (Explain) Pd 1 mo/ 2wk

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
4-23-84	TTD	5 29 83	4 10 84	45 6	$ 134.83	$ 6412.20
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 6412.20

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 5 / 29 / 83
b. First Payment Date 6 / 16 / 83
21. Date Disability Ended 4 / 12 / 84

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ 130.00
c. Employer Attorney Fees $ ____ d. Medical $ 105.91
e. Second Injury Fund ☐ $ 2521.73 Pd Check to SIF Attached f. Rehabilitation $ ____
g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work ____ Date ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____

24. ☑ Released for Work Date 4 / 13 / 84
☑ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks:
Report was 3 days late. No written report from DR. No claimant contact present address unknown could not contact by letter. Will try phone.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
HELEN L. BEVACQUA, CLAIMSREP.	Helen L. Bevacqua	10-25-84

37. Address (If different from No. 10) City State Zip Telephone

Form 07-6104(Rev. 6/82) EXPLANATIONS AND INSTRUCTIONS ON BACK

SCOTT WETZEL SERVICES, INC.

AN AFFILIATE OF THE HOME GROUP INC

SPEED MEMO

TO Ron Holt	OFFICE		
FROM Rene Murray	OFFICE	FILE NO.	
SUBJECT Renaud - Lentes vs. Ray & Jane		DATE	1/23/85

Ron —

Here's another one we owe. Lisa filed the report one day late & for our lousy day we owe $110.00. Please have the check drawn & State of Alaska - Second Injury Fund.

2 Months,

Rene

Because we wish to serve you more quickly, we use this speed memo.

By Rene

ADM-107

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Linda Lowers
Employee,

vs.

Lamonts Apparel
Employer

and

Scott Wetzel Services
Insurer,
Defendants.

AFFIDAVIT

Case No. 400969

State of Alaska)
) ss.
First Judicial District)

J. Paul House, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made 2-1-84 was postmarked 2-16-84 and received 2-21-84 in Juneau, AK.

J. Paul House

Subscribed and sworn to before me this 18th day of April, 1984, in Juneau, Alaska.

Elaine Vanderlande
Notary Public for Alaska
My commission expires 6/24/87.

07-G6LH

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE 04/26/84

SCOTT WETZEL SERVICES
741 SESAME ST SUITE 1A

ANCHORAGE AK 99503

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 14 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT WAS FILED 1 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $110.00

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE: LEWERS, LINDA L.
SRA BOX 1858-E

ANCHORAGE AK 99516
EMPLOYER: LAMONTS APPAREL
2002 W BENSON BLVD

ANCHORAGE AK 99503
INJURY DATE: 01/09/84
AWCB CASE NO: 400969
REF YOUR CLAIM 459

VERY TRULY YOURS,

J. PAUL HOUSE, ADMINISTRATOR
SECOND INJURY FUND

FORM NO. 6104R

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT
(FOR INJURY DATES JANUARY 1, 1980 AND AFTER)

AWCB Case Number: 4/10491-84

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
LEWERS, LINDA L.	459	1 / 9 / 84

4. Address	5a. ☐ Single ☐ Married	5b. No. of Dependents	6. Social Security Number
SRA BOX 1858-F			526 - 58 - 2473

City	State	Zip	Telephone	AWCB JUNEAU	7. Birthdate
ANCHORAGE	AK.	99516	345-5845	FEB 2 1984	1 / 10 / 45

8. Employer	9. Insurer/Adjusting Company
PAY N SAVE	SELF-INSURED
10. Address: 1511 6TH AVENUE	11. Address: c/o SCOTT WETZEL SERVICES
City: SEATTLE State: WA. Zip: 98101 Telephone:	City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

12. METHODS
- ☐ 1. Awaiting gross earnings documents
- ☐ 2. Two years gross earnings — Documents received: / / (Date)
- ☐ 3. Nature of work/work history
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.
- ☐ 6. Other: Social Security (42) or (121j) (33)

13. If method 3, 4, or 5, how did you figure gross weekly earnings?

☐ 14. Board and room included. Explain how you figured it.

15. RATE

☐ a. Alaska TTD, PTD, death or scheduled PPC	b. Gross Earnings $ ÷ 100 weeks = $ (Gross Weekly Earnings) − Tax-FICA x 80% = $		Alaska Weekly Rate	Alaska Max. or Min. $
☐ c. Alaska unscheduled PPD or TPD	d. Alaska Wk. TTD Rate $ − (Wk. Earning Capacity * − Tax-FICA x 80% = $)		= $ Alaska Weekly Rate	Alaska Max. or Min. $
☐ e. Out-of-state TTD, TPD, PPD, PTD or death	f. State Avg. Wk. Wage $ ÷ Alaska Avg. Wk. Wage $ = State Ratio %		X $ Alaska Weekly Rate	= $ State Weekly Rate

g. State or Country — h. Date Left / / — i. Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly (%)

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☒ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
2-1-84	(11)	1-30-84	2/11/84	1 6	$ 110.00	$ 214.26
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 214.26

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 1 / 17 / 84	22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
b. First Payment Date 2 / 1 / 84	c. Employer Attorney Fees $ ____ d. Medical $ -0-
21. Date Disability Ended 1/31/84	e. Second Injury Fund $ ____ f. Rehabilitation $ ____
	☐ $ Check to SIF Attached g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work / / (Date) ☐ At New Job ☐ At Same Job Occupation ____ Weekly Pay Rate $	24. ☒ Released for Work Date 2/2/84 ☒ Regular Work ☐ Modified Work	25. ☐ Moved from Alaska 27. ☐ Returned to Alaska 29. ☐ Recomputation 31. ☐ Other	26. ☐ Compromise and Release 28. ☐ Controversion (Attach 07-6105) 30. ☐ Board Order 32. ☐ Lack Recent Medical Report

33. Remarks:

cc: AWCB FILE

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
LISA ZOLLINGER JR CLAIMS EXAMINER	Lisa Zollinger	2 / 16 / 84

37. Address (If different from No. 11)	City	State	Zip	Telephone
741 SESAME STREET. SUITE 1A	ANCHORAGE	ALASKA	99503	561-1725

Form 07-6104A (Temporary - in printing) EXPLANATIONS AND INSTRUCTIONS ON BACK

* From AWCB tables

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

January 15, 1985

Ms. Renee Murray
Vice-President
Scott Wetzel Services Incorporated
741 Sesame Street, Suite 1A
Anchorage, AK 99503

Dear Ms. Murray:

Re: David Ford vs. State of Alaska
D/A 3-10-83 Case No. 304511

Although I thought I had carefully reviewed all cases on which Second Injury Fund petitions for late reporting were prepared, in this instance I believe you are correct, and a penalty should not be pursued.

Using the June 2, 1983 corrected payment date, your June 15, 1983 report would have been timely. I believe the date benefits were terminated may be subject to question concerning whether the correct date or the actual date should be used. The statute was changed July 1, 1984 in an attempt to clarify the date to be used in assessing penalties, and clarification of the earlier version does not appear critical now.

A similar question may arise, however, under the law change when a claim is paid beyond the return-to-work date. The 28 days allowed to file the report should reduce the frequency, although my understanding of the intent of the new provision is that the last correct payment date will be the one enforced. The reasoning is that the adjuster has an obligation to follow the claim carefully enough to know what is happening and report accurately. Particularly when the former employer is the same one where the worker returns to work, the employer should be educated to report the return to work or have to pay the late reporting penalty himself, passed on by the insurer.

That will be a question to resolve if and when the circumstances arises.

Very truly yours,

Elaine VanderSande

Elaine VanderSande
Workers' Compensation Officer
Second Injury Fund

07-G6LH

cc: W.C.C.A
Jack Thompson, President
2216 Post Road
Anchorage, AK 99501

Rep. Virginia Collins
Pouch V
Juneau, AK 99811

Randall J. Weddle, Esq.
2550 Denali, Suite 700
Anchorage, AK 99503

Scott Wetzel Services Incorporated
An Affiliate of The Home Group Inc
741 Sesame Street • Suite 1A • Anchorage, Alaska 99503
Phone (907) 561-1725

January 9, 1985

Elaine VanderSande
Workers Compensation Officer
Second Injury Fund
Box 1149
Juneau, Alaska 99802

RE: David Ford vs. State of Alaska
D/A: 3/10/83 Case No. 304511

Dear Ms. VanderSande:

This will acknowledge receipt of your letter of December 28, 1984 notifying us of your decision that we owe a $750.00 penalty and your filing of the notice of Statement of Readiness to Proceed hearing.

We don't owe this penalty. Marion Berry attempted to explain it, but it is a complicated situation, so I am going to try again.

First of all, I will tell you the facts and then explain our error which created this whole scenario.

The fact is that we paid Mr. Ford TTD benefits from 3/14/83 through 6/2/83. The last payment was made on 6/2/83. (Copies of the last 3 checks issued are attached.)

After making the final payment on 6/2/83, we filed a Termination Report on 6/15/83. When that report was completed, WE MADE AN ERROR AND INCORRECTLY INDICATED THAT THE FINAL PAYMENT HAD BEEN MADE ON 5/6/83 RATHER THAN 6/2/83.

I frankly have no idea why our clerical personnel picked up the incorrect date, but the fact is she did and we, therefore, filed a corrected report on 6/30/83 indicating the error and showing the final payment made on 6/2/83.

This final check was, in fact, returned to us by the claimant inasmuch as he had returned to work at an earlier date. We had an overpayment from 5/9/83 through 5/19/83, but for the purposes of the Compensation Report and the alleged penalty, the fact remains that we did issue the final check on 6/2/83 and we did file the Termination Report within the 14 day period following the final payment.

If we were to accept your reasoning, every time we overpay someone we would owe a late reporting penalty because we continued payment beyond their return to work date - for whatever reason. In this case, we relied on the doctor's report, which indicated he was not released for work. However, as you know, he returned to work without a doctor's release, and for this you want us to pay a $750.00 penalty. Can you possibly believe this is justified?

If so, we request a formal hearing in Anchorage before the full Board.

You will note from the attached copies that we had to file SIX Compensation Reports, and it still isn't good enough for you. No wonder we are up in arms.

Very truly yours,

Renee Murray
Vice-President

RM/jlh
Enclosures

cc: WCCA Committee
cc: Rep. Virginia Collins
cc: Randy Weddle, Esq.
cc: SWS-Bremerton

COPY SERVED ON (HSS) State of AK / Scott Wetzel Services C-RRR

PETITIONED on 12-28-84

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P. O. Box 1149
Juneau, Alaska 99811

AWCB Case Number: 304511

(Not to be used by injured employee)

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim No.	3. Date of Injury
Ford David P.	647	3 / 10 / 83
4. Address		5. Social Security Number
		329 - 80 - 0804
City State Zip Code Telephone		6. Date of Birth
		5 / 6 / 49
7. Employer	8. Insurer	
State of Alaska (HSS)	Self Insured/Scott Wetzel Services	
9. Address	10. Address	
400 Gambell, Suite 201	741 Sesame St. Suite 1-A	
City State Zip Code Telephone	City State Zip Code Telephone	
Anchorage, Alaska 99503	Anchorage, Alaska 99503 561-1725	

REASON FOR PETITION - CHECK APPROPRIATE BOXES AND COMPLETE QUESTIONS IN DETAIL.

☐ JOIN ADDITIONAL EMPLOYER AND/OR INSURER: (ATTACH PROOF OF SERVICE ON EMPLOYER AND/OR INSURER)

11. Name of Employer to be Joined	12. Insurer
13. Address	14. Address
City State Zip Code	City State Zip Code
15. Dates Injured Employee Worked for Employer to be Joined	16. Dates of Coverage (Use when joining only insurer)
17. Date of Alleged Injury	18. Nature of Alleged Injury

If more than one employer and/or insurer to be joined, attach additional page and provide above information for each employer and/or insurer.

☐ PETITION TO TERMINATE BENEFITS (CHECK TYPE TO BE TERMINATED):

19. ☐ Temporary Total Disability ☐ Temporary Partial Disability ☐ Permanent Partial Disability ☐ Permanent Total Disability ☐ Medical Benefits
☐ Other:

20. Reason for termination(s)

21. If you are seeking termination of temporary compensation and allege the disability is permanent, report total compensation paid:

Type	From	Through	Weeks and Days	Rate	Amount
				$	$
				$	$
				$	$
				$	$

22. Date When Disability Became Permanent

☒ OTHER (STATE IN DETAIL BELOW; ATTACH ADDITIONAL PAGE IF NECESSARY):

Request Board Order on late reporting penalty of $ 750.00 per AS 23.30.155(c) based upon compensation report termination payment of may 6, 1983 which was 27 days late.

The Second Injury Fund requests a determination based upon the information in the case file.

COMPLETE AND ATTACH A MEDICAL SUMMARY (Form 07-6103).
ATTACH PROOF OF SERVICE

23. Name of Individual Submitting this Form (Print or Type)	24. Signature	25. Date
Elaine VanderSando	Elaine VanderSando	12/28/84
26. Address City State Zip Code		
Second Injury Fund P.O. Box 1149, Juneau, Alaska 99802		
27. Attorney's Name and Firm Name (If Represented)		28. Telephone
29. Attorney's Address City State Zip Code		

COPY SERVED ON
(HSS) State of Ak/ Scott Wetzel Services
C-RRR
By AWCB on 12-28-84

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P.O. Box 1149
Juneau, Alaska 99802

STATEMENT OF READINESS TO PROCEED

AWCB Case Number: 304511

BEFORE YOU COMPLETE AND SUBMIT THIS FORM, READ CAREFULLY.

1. Use only to request the scheduling of a pre-hearing or hearing after employee has filled an "Application for Adjustment of Claim" (Form 07-6106) or employer/insurer has filed a "Petition" (Form 07-6111).
2. Note that once a hearing has been scheduled, a continuance will be permitted only for good cause following a written stipulation filed with the Board before the hearing or an oral motion at the time for the hearing. If a continuance is granted, there may be a significant delay before your case is rescheduled.
3. You should complete and submit this form only if you are fully prepared for a hearing.
4. Plan to be present at the hearing in person or represented by an attorney.

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Date of Injury
Ford, David F.	647	3 / 10 / 83
4. Address		5. Social Security Number
City / State / Zip Code / Telephone		329-80-0804
		6. Date of Birth: 5 / 6 / 49
7. Employer	8. Insurer/Adjusting Company	
State of Alaska (HSS)	Self Insured / Scott Wetzel Services	
9. Address	10. Address	
400 Gambell, Suite 201	741 Sesame St. Suite 1-A	
City / State / Zip Code / Telephone	City / State / Zip Code / Telephone	
Anchorage, Alaska 99503	Anchorage, Alaska 99503 561-1725	

Section 1

Before your case will be scheduled for a pre-hearing or hearing, you MUST comply with the following instructions:

11. Complete the entire form except (a) Section 4 if requesting a pre-hearing, or (b) Section 3 if requesting a hearing.
12. Attach a "Medical Summary" (Form 07-6103).
13. Attach proof of service upon opposing parties of the "Medical Summary" form and this form.
14. Mail this form to the Board's address in the city you want the pre-hearing or hearing held. If you request "Other", mail to the Board's Juneau address.

Section 2

15. The ☐ Employee, ☐ Employer, ☐ Insurer, or ☐ Physician requests that this case be ☒ Second Injury Fund - Decided on written record contained in Board file. set for a ☐ Pre-hearing or ☐ Hearing in:

☐ Anchorage	☐ Fairbanks	☒ Juneau	☐ Other (Check one)
Pouch 7-019	675 7th Avenue	Box 1149	☐ Ketchikan
Anchorage, AK 99510	Station "J"	Juneau, AK 99802	☐ Sitka
(907) 264-2424	Fairbanks, AK 99701	(907) 465-2790	
	(907) 452-1509		

16. Employee is now receiving compensation payments: ☐ YES ☐ NO Weekly Rate $ _____

Section 3

17. ☐ A pre-hearing is requested to:

☐ Frame Issues, ☐ Record Stipulations, ☐ Join Necessary Parties, or ☐ Other (Explain): _____

Section 4

18. ☐ A regular hearing is requested. If there are additional issues not listed on the "Application for Adjustment of Claim" or "Petition", please attach an amended Application or Petition.
19. I expect to present ____ witnesses, including ____ medical witnesses, and estimate the time required for my portion of the hearing will be ____ minutes.
20. Comments: no testimony / witness

21. Name of individual submitting this Form (Print or Type)	22. Signature	23. Date
Elaine VanderSande	Elaine VanderSande	12/28/84
24. Address	City / State / Zip Code	
Second Injury Fund P.O. Box 1149, Juneau, Alaska 99802		
25. Attorney's Name and Firm Name (if represented)	26. Telephone	
27. Attorney's Address	City / State / Zip Code	

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

December 28, 1984

Ms. Marion C. Berry
Scott Wetzel Services
741 Sesame Street, Suite 1-A
Anchorage, AK 99503

Dear Ms. Berry:

Re: David P. Ford vs. State of Alaska
D/A 3-10-83 Case No. 304511
Insurer Claim No. 647

You responded on June 28, 1983 to J. Paul House's June 23, 1983 notice of late report penalty and explained that the adjuster was not notified of David Ford's return to work several weeks before it was anticipated.

AS 23.30.155( )oes not provide an option to waive penalty, and the Fund cannot excuse ...ice not timely filed even though the period of disability changed after receipt of additional information. If the employer did not notify the adjuster of the return to work, you should discuss this failure with the employer as the employer/insurer/adjuster are jointly responsible for prompt filing.

Very truly yours,

Elaine VanderSande
Workers' Compensation Officer
Second Injury Fund

07-GGLH

5009

CLAIM NO. 390-110-647 | SCOTT WETZEL SERVICES, INC. 741 SESAME STREET, SUITE 1A ANCHORAGE, ALASKA 99503 | CLAIMANT FORD, DAVID P.

DATE ISSUED 5/6/83 | TYPE PMT 3 | CLOSE | DATE OF LOSS 3/10/83 | LOCATION CHUGIAK

PAYEE FEDERAL I.D. NO. | IN FULL SETTLEMENT OF TEMPORARY TOTAL DISABILITY ---/11 thru 5/13/83 (4 day waiting period) PLUS TTD ADJUSTMENT 5/14 thru 5/5/83 (2wks) 30/227

PAY ---TWO THOUSAND, ONE HUNDRED, FORTY THREE & 74/100------ DOLLARS $ 2,143.74**

TO: DAVID P. FORD
1547 E. 27th Avenue
Anchorage, Alaska 99504

STATE OF ALASKA
W/C CLAIMS PAYMENT ACCOUNT
BY SCOTT WETZEL SERVICES, INC.

NOT NEGOTIABLE

3145

NATIONAL BANK OF ALASKA 52-5/1252
SPENARD BRANCH
ANCHORAGE, ALASKA 99503

CLAIM NO. 390-110-647 | SCOTT WETZEL SERVICES, INC. 741 SESAME STREET, SUITE 1A ANCHORAGE, ALASKA 99503 | CLAIMANT FORD, DAVID P.

DATE ISSUED 5/18/83 | TYPE PMT 5 | CLOSE | DATE OF LOSS 3/10/83 | LOCATION CHUGIAK, AK.

PAYEE FEDERAL I.D. NO. | IN FULL SETTLEMENT OF TEMPORARY TOTAL DISABILITY 5/6 THRU 5/19/83 (2 WEEKS) 30/222

PAY FIVE HUNDRED EIGHTY EIGHT DOLLARS AND 72/100---------- DOLLARS $ 588.72

TO: DAVID P. FORD
1547 E 27th AVE
ANCHORAGE, AK. 99504

STATE OF ALASKA
W/C CLAIMS PAYMENT ACCOUNT
BY SCOTT WETZEL SERVICES, INC.

NOT NEGOTIABLE

3308

NATIONAL BANK OF ALASKA 52-5/1252
SPENARD BRANCH
ANCHORAGE, ALASKA 99503

CLAIM NO. 390-110-647 | SCOTT WETZEL SERVICES, INC. 741 SESAME STREET, SUITE 1A ANCHORAGE ALASKA 99503 | CLAIMANT FORD, DAVID P.

DATE ISSUED 6/2/83 | TYPE PMT 3 | CLOSE | DATE OF LOSS 3/10/83 | LOCATION CHUGIAK, AK.

PAYEE FEDERAL I.D. NO. | IN FULL SETTLEMENT OF TEMPORARY TOTAL DISABILITY--5/20 thru 6/2/83 (2 wks) 30/22

PAY ---FIVE HUNDRED, EIGHTY EIGHT & 72/100----- DOLLARS $ 588.72**

TO: DAVID P. FORD
1547 E. 27th Avenue
Anchorage, Alaska 99504

6/16/83

STATE OF ALASKA
W/C CLAIMS PAYMENT ACCOUNT
BY SCOTT WETZEL SERVICES, INC.

NOT NEGOTIABLE

feel we owe $750.00 on,

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 304511

1. Employee's Name (Last, First, Middle Initial): FORD, DAVID P
2. Insurer Claim Number: 647
3. Injury Date: 3 / 10 / 83
4. Address: 1547 E 27th AVE
City: ANCHORAGE State: AK Zip: 99504 Telephone: 276-5427
5. Social Security Numb: 329 - 80 - 0804
6. Birthdate: AGE/33 /
7. Employer: STATE OF ALASKA
8. Address: 400 GAMBELL, SUITE 201
City: ANCHORAGE State: AK Zip: 99503 Telephone:
9. Insurer/Adjusting Company: SELF INSURED
10. Address: SCOTT WETZEL SERVICES, INC.
City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: ___/___/___ Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $

15. HOW RATE WAS FIGURED

	a. Gross Wages	Employee Avg. Wk. Wage	Alaska Weekly Rate	Alaska Max. or Min.
☐ a. Alaska TTD, PTD, death or scheduled PPD	$	÷ 52 weeks = $	X 66 2/3% = $	$
	b. Employee Avg. Wk. Wage	Earning Capacity	Difference	Alaska Weekly Rate	Alaska Max. or Min.
☐ b. Alaska unscheduled PPD or TPD	$	−$	=$	X 66 2/3% = $	$
	c. State Avg. Wk. Wage	Alaska Avg. Wk. Wage	State Ratio	Alaska Weekly Rate	State Weekly Rate
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	$	÷ $	= %	X $	= $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☒ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☒ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☑ i. OTHER (Explain) PPD PAYMENT

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
	TTD	3/11/83	5/19/83	10	$ 294.36	$ 3405.16
11/8/83	PPD	-----20% OF LEFT ARM----------			$	$ 8275.44
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 11,679.60

18. Impairment Rating: 20 % of L ARM ; ___ % of ___ ; ___ % of ___

19. ☑ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?
$45,680. X 20% = $9136.

20. a. Date Disability Began 3 / 11 / 83
b. First Payment Date 5 / 24 / 83
21. Date Disability Ended 5 / 19 / 83

22. a. Employee Attorney Fees $ ___ b. Late Report Penalties $ ___
c. Employer Attorney Fees $ ___ d. Medical $ 50,020.83
e. Second Injury Fund $ 675.02 f. Rehabilitation $ ___
☑ $ 524.16 Check to SIF Attached g. Other $ ___

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☒ Returned to Work 5 / 9 / 83 Date ☐ At New Job ☐ At Same Job
Occupation ___
Weekly Pay Rate $ ___
24. ☐ Released for Work Date ___/___/___
☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: OVERPAYMENT RECOVERED.
CC: ANCB
CC: SOA PR
CC: FILE
CC: SRS BREMERTON

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print): MARION C. BERRY/CLAIMS EXAMINER
35. Signature: [signature]
36. Date: 11 / 8 / 83

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 304511

1. Employee's Name (Last, First, Middle Initial): FORD, DAVID P.
2. Insurer Claim Number: 647
3. Injury Date: 3 / 10 / 83
4. Address: 1517 E 27th AVE
5. Social Security Number: 329 - 80 - 0804
City: ANCHORAGE State: AK Zip: 99504 Telephone: 276-5427
6. Birthdate: AGE 33
7. Employer: STATE OF ALASKA
8. Insurer/Adjusting Company: SELF INSURED
9. Address: 400 GAMBELL, SUITE 201
10. Address: SCOTT WETZEL SERVICES, INC.
City: ANCHORAGE State: AK Zip: 99503 Telephone:
City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: ___/___/___ Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? ____

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured. ____

14. RATE $

15. HOW RATE WAS FIGURED

☐ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $	÷ 52 weeks = $ Employee Avg. Wk. Wage	× 66 2/3% = $ Alaska Weekly	Alaska Max. or Min.
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	− $ Earning Capacity	= $ Difference	× 66 2/3% = $ Alaska Weekly Rate
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	÷ $ Alaska Avg. Wk. Wage	= % State Ratio	× $ Alaska Weekly Rate = $ State Weekly Rate

(1) State or Country (2) Date Left ___/___/___ (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: ___/___/___ ☐ h. ANNIVERSARY ☒ i. OTHER (Explain) CORRECTION

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
6/2/83	TTD	5/11/83	5/19/83	10	$ 294.36	$ 3406.16
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 3406.16

18. Impairment Rating: ____% of ____; ____% of ____; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? ____

20. a. Date Disability Began 3 / 11 / 83
b. First Payment Date 3 / 24 / 83
21. Date Disability Ended 5 / 19 / 83

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ 39,041.49
e. Second Injury Fund $ 148.86 f. Rehabilitation $ ____
☐ $ Check to SIF Attached g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☒ Returned to Work 5 / 9 / 83 Date ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____

24. ☐ Released for Work Date ___/___/___
☐ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: OVERPAYMENT 5/9/83 THRU 5/19/83 = 1 WEEK 4 DAYS = 462.56 OVERPAYMENT LAST PAYMENT MADE ON 6/2/83, PAYING CLAIMANT THRU 6/2/83, BUT WAS RETURNED BY CLAIMANT ADVISING HE RETURNED TO WORK 5/9/83.

CC: ANCB CC: SOA PR CC: FILE CC: SOA RISK MANAGEMENT CC: SWS BREMERTON

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print): MARION C. BERRY/CLAIMS EXAMINER
35. Signature: [signature]
36. Date: 6 / 30 / 83
37. Address (If different from No. 10) City State Zip Telephone

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 304511

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
FORD, DAVID P.	647	3 / 10 / 83
4. Address		**5. Social Security Number**
1547 E 27th AVE		329 - 80 - 0804
City / State / Zip / Telephone		6. Birthdate
ANCHORAGE AK 99504 276-5427		AGE 33 /
7. Employer	**8. Insurer/Adjusting Company**	
STATE OF ALASKA (HSS)	SELF INSURED	
9. Address	**10. Address**	
400 GAMBELL, SUITE 201	SCOTT WETZEL SERVICES, INC.	
City / State / Zip / Telephone	City / State / Zip / Telephone	
ANCHORAGE AK 99503		

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: ___/___/___ Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? ____

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured. ____

14. RATE $ ____

15. HOW RATE WAS FIGURED

☐ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $	Employee Avg. Wk. Wage ÷ 52 weeks = $	Alaska Weekly Rate X 66 2/3% = $	Alaska Max. or Min. $
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity −$	Difference =$	Alaska Weekly Rate X 66 2/3% = $	Alaska Max. or Min. $
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate X $	State Weekly Rate = $

(1) State or Country ____ (2) Date Left ___/___/___ (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☒ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: ___/___/___ ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
5/6/83	TTD	5/11/83	5/19/83	10	$ 294.56	$ 3405.16
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 3406.16

18. Impairment Rating: ____% of ____; ____% of ____; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? ____

20. a. Date Disability Began 3 / 11 / 83
b. First Payment Date 3 / 24 / 83
21. Date Disability Ended 5 / 19 / 83

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ 37,401. 4
e. Second Injury Fund $ 148.86 f. Rehabilitation $ ____
☐ $ 148.86 Check to SIF Attached g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☒ Returned to Work 5 / 9 / 83 Date ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____

24. ☐ Released for Work Date ___/___/___
☐ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: OVERPAYMENT FROM 5/9/83 THRU 5/19/83, PERIOD OF 1 WEEK 4 DAYS, OF $462.56.

CC: AWCB
CC: SOA PR
CC: FILE
CC: SOA RISK MANAGEMENT CC: SWS BRUERTON

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
MARION C. BERRY/CLAIMS EXAMINER		6 / 15 / 83

37. Address (If different from No. 10) 711 SESAME ST. SUITE 1-A City ANCHORAGE State AK Zip Telephone

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

Adjudication Claim Number: 304511

1. Employee's Name (Last, First, Middle Initial): FORD, DAVID P.
2. Insurer Claim Number: 647
3. Injury Date: 3 / 10 /83
4. Address: 1547 E. 27th Avenue
5. Social Security Number: 239 - 80 - 0804
City: ANCHORAGE, State: ALASKA Zip: 99504 Telephone: 276-5427
6. Birthdate: /AGE 33/
7. Employer: STATE OF ALASKA (HSS)
8. Insurer/Adjusting Company: SELF INSURED c/o SCOTT WETZEL SERVICES, INC.
9. Address: 400 CAMBELL, SUITE 201
City: ANCHORAGE, State: ALASKA Zip: 99503 Telephone:
10. Address: 741 Sesame Street
City: ANCHORAGE, State: ALASKA Zip: 99503 Telephone: 561-1725

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☒ 2. Highest of three years, 19 82 — Documents received: 5 / 4 / 83 (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $ 294.36

15. HOW RATE WAS FIGURED

☒ a. Alaska TTD, PTD, death or scheduled PPD: a. Gross Wages $22,959.64 ÷ 52 weeks = $ 441.53 (Employee Avg. Wk. Wage) × 66 2/3% = $ 294.36 (Alaska Weekly Rate)

☐ b. Alaska unscheduled PPD or TPD: b. Employee Avg. Wk. Wage $ — Earning Capacity $ = Difference $ × 66 2/3% = $ (Alaska Weekly Rate)

☐ c. Out-of-state TTD, TPD, PPD, PTD or death: c. State Avg. Wk. Wage $ ÷ Alaska Avg. Wk. Wage $ = State Ratio % × $ (Alaska Weekly Rate)

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska?

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☒ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
5/6/83	TTD	3/11/83			$ 294.36	$
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $

18. Impairment Rating: ____% of ____; ____% of ____; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 3 / 11 / 83
b. First Payment Date 3 / 24 / 83
21. Date Disability Ended CONTINUING

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ ____
e. Second Injury Fund $ ____ f. Rehabilitation $ ____
☐ $ Check if SIF Attached g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work ____ (Date) ☐ At New Job ☐ At Same Job
Occupation ____ ____
Weekly Pay Rate $
24. ☐ Released for Work Date / /
☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (AS 23.30.155)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks:

cc: AWCB
cc: SOA-PAYROLL
cc: FILE

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print): MARION C. BERRY, CLAIM EXAMINER
35. Signature:
36. Date: 5 / 6 /83
37. Address (If different from No. 10) City State Zip Telephone

jh

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number

1. Employee's Name (Last, First, Middle Initial): FORD, DAVID P.
2. Insurer Claim Number: 647
3. Injury Date: 3 / 10 / 83
4. Address: 1547E 27th AVENUE
City: ANCHORAGE State: AK Zip: 99504 Telephone: 276-5427
5. Social Security Number: 239 - 80 [illegible]
6. Birthdate: AGE 33/ /
7. Employer: STATE OF ALASKA (DHSS)
8. Insurer/Adjusting Company: SELF INSURED
9. Address: 400 GAMBELL, SUITE 201
City: ANCHORAGE State: AK Zip: 99503 Telephone:
10. Address:
City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 81 — Documents received: 3 / 29 / 83 (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $ 88.98

15. HOW RATE WAS FIGURED

☒ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $ 6940.20	÷ 52 weeks = $ 133.47	X 66 2/3% = $ 88.98	Alaska Weekly Rate
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	− $	= $	X 66 2/3% = $
		Earning Capacity	Difference	Alaska Weekly Rate
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	÷ Alaska Avg. Wk. Wage $	= State Ratio %	X Alaska Weekly Rate $ = $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No — If "No" explain

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☒ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
4/7/83	TTD	3/14/83			$ 88.98	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $

18. Impairment Rating: ____% of ____ : ____% of ____ : ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 3 / 11 / 83
b. First Payment Date 3 / 24 / 83
21. Date Disability Ended CONTINUING / /

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ ____
e. Second Injury Fund $ ____ f. Rehabilitation $ ____
☐ $ Check to SIF Attached g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work ____ (Date) ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____
24. ☐ Released for Work Date / /
☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controverted (Attach 07-6105)
30. ☐ Board Order
32. ☐ Last Recent Medical Report

33. Remarks:
CC: AWCB
CC: SOA-PAYROLL
CC: FILE

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

34. Name and Title of Person Submitting Report (Type or Print): CLARE HIRATSUKA/CLAIMS EXAMINER
35. Signature: Clare Hiratsuka
36. Date: 4 / 7 / 83
37. Address (If different from No. 10): 741 SESAME ST. SUITE 1-A City: ANCHORAGE State: AK Zip: 99503 Telephone: 561-1725 RH

Form 07-6104 (Rev. 6/82) EXPLANATIONS AND INSTRUCTIONS ON BACK

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number:

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
FORD, DAVID P.	647	3 / 10 / 83
4. Address		**5. Social Security Number**
1547 E 27th AVENUE		239 - 80 - 0804
City: ANCHORAGE State: AK Zip: 99504 Telephone:		**6. Birthdate** 33 / /
7. Employer	**8. Insurer/Adjusting Company**	
STATE OF ALASKA (DHSS)	SELF-INSURED	
9. Address	**10. Address**	
400 GAMBELL, SUITE 201	c/o SCOTT WETZEL SERVICES, INC.	
City: ANCHORAGE State: AK Zip: 99503 Telephone:	City: State: Zip: Telephone:	

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☒ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: ____ / ____ / ____ (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? ____

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured. ____

14. RATE $ 65.00

15. HOW RATE WAS FIGURED

☒ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $	Employee Avg. Wk. Wage ÷ 52 weeks = $	Alaska Weekly Rate × 66 2/3% = $	Alaska Max. or Min. $ 65.00
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity −$	Difference =$	Alaska Weekly Rate × 66 2/3% = $ / Alaska Max. or Min. $
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate X $ / State Weekly Rate = $

(1) State or Country ____ (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☒ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
3/24/83	TTD	3/14/83			$ 65.00	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $

18. Impairment Rating: ____% of ____ ____: ____% of ____ : ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? ____

20. a. Date Disability Began 3/11/83
b. First Payment Date 3/24/83
21. Date Disability Ended continuing

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ ____
e. Second Injury Fund $ ____ f. Rehabilitation $ ____
☐ $ Check to SIF Attached g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work ____ / ____ / ____ (Date) ☐ At New Job ☐ At Same Job
Occupation ____ Weekly Pay Rate $ ____
24. ☐ Released for Work Date / / ☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
26. ☐ Compromise and Release
27. ☐ Returned to Alaska
28. ☐ Controversion (Attach 07 6105)
29. ☐ Recomputation
30. ☐ Board Order
31. ☐ Other
32. ☐ Lack Recent Medical Report

33. Remarks:

cc: AWCB-Juneau SOA-Payroll

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
CLARE HIRATSUKA, CLAIMS EXAMINER	[signature]	3 / 24 / 83

37. Address (If different from No. 10) 741 SESAME STREET SUITE 1A City ANCHORAGE State AK Zip 995[illegible] Telephone [illegible]

SCOTT WETZEL SERVICES, INCORPORATED
AN AFFILIATE OF THE HOME GROUP INC.

INTER OFFICE MEMORANDUM

TO	OFFICE	FILE NO.
W.C.C.A. COMMITTEE		
FROM	OFFICE	
RENEE MURRAY		
SUBJECT		DATE
PENALTY CASE (ROBERT BRETZ VS ALASKA PULP CORPORATION) D/A: 4/24/82		12/19/84

THIS IS A CASE THAT WAS CONTROVERTED AND THE CLAIMANT WAS OVERPAID BY SEVERAL THOUSAND DOLLARS, BUT A $1,000.00 PENALTY WAS ASSESSED FOR FAILURE TO FILE A SUSPENSION REPORT.

THE INITIAL REPORT WAS FILED ON 5/7/82 BY BETTY SEXTON IN OUR JUNEAU OFFICE.

ON 4/8/83, SHE FILED A RATE CHANGE REPORT.

ON 5/16/83, SHE FILED A CONTROVERSION WHICH, OF COURSE, INDICATES THAT BENEFITS HAVE STOPPED, BUT SHE FAILED TO FILE A SUSPENSION REPORT.

THE FILE WAS TRANSFERRED TO OUR OFFICE AND WE CAUGHT THE ERROR AND FILED A TERMINATION REPORT AND A NOTICE OF OVER-PAYMENT TO THE CLAIMANT IN THE AMOUNT OF $6,624.12 AND WE PAID THE SIF, ON 4/9/84.

ON 5/16/84, WE FILED A CORRECTION OF THE 4/9/84 REPORT.

THE CLAIM WAS SUBSEQUENTLY SETTLED ON A COMPROMISE AND RELEASE (AND WE RECOVERED THE $6,624.12 OVERPAYMENT) AND WE FILED THE FINAL TERMINATION REPORT ON 9/10/84.

NOW THE BOARD WOULD LIKE US TO PAY $1,000.00 FOR FAILURE TO FILE A SUSPENSION REPORT WHEN WE CONTROVERTED THE CLAIM ON 5/16/83.

RENEE MURRAY

ADM-112

SCOTT WETZEL SERVICES, INCORPORATED

AN AFFILIATE OF THE HOME GROUP INC

INTER OFFICE MEMORANDUM

TO	OFFICE	FILE NO
Randy Weddle, Esq.	= Faulkner, Banfield, Doogan & Holmes	
FROM	OFFICE	
Renee Murray		
SUBJECT		DATE
PENALTY CASE (Robt. Bretz vs. Alaska Pulp Co. D/A: 4/24/82		10/31/84

Randy,

The Board has started sending penalty letters again and we are receiving a rash of them, so here's another one for you.

The initial report was filed on 5/7/82 by Betty Sexton in our Juneau office.

On 4/8/83, she filed a rate change report.

On 5/16/83 she filed a Controversion, but failed to file a suspension report.

The file was transferred to our office and we caught the error and filed a Termination Report and a notice of over-payment of $6,624.12 and we paid the SIF, on 4/9/84.

On 5/16/84, we filed a correction of the 4/9/84 report.

The claim was subsequently settled on a Compromise and Release (and we recovred the $6,624.12 overpayment) and we filed the final Termination Report on 9/10/84.

Now the Board would like us to pay $1,000.00 for failure to file a Suspension Report when we controverted the claim on 5/16/83.

I sure hope you can get us out of this one.

Let me know if you need anything else.

P.S. This case points out the absurdity of this system by the requirement of filing report, after report, after report. Do you think something can be done legislatively this year? Any suggestions? I am sure willing to devote my time and efforts to it.

cc Dalton

100313 TL

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99802
(907) 465 2790

DATE ~~9/11/84~~
9/12/84

SCOTT WETZEL SERVICES
741 SESAME ST SUITE 1A

ANCHORAGE AK 99503

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 28 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

A REVIEW OF OUR RECORDS SHOWS YOUR COMPENSATION REPORT FOR A PAYMENT MADE WAS FILED 311 DAYS LATE. AN AFFIDAVIT STATING THIS FACT IS ATTACHED. IF YOU TIMELY MAILED YOUR REPORT, PLEASE RETURN A COPY OF THE REPORT TOGETHER WITH YOUR AFFIDAVIT OF MAILING. IF YOU DO NOT SUBMIT AN AFFIDAVIT, YOU MUST PAY A LATE REPORTING PENALTY OF $1,000.

IF I DO NOT RECEIVE YOUR CHECK OR AFFIDAVIT WITHIN 30 DAYS, THE FUND WILL PETITION THE BOARD FOR AN ORDER REQUIRING PAYMENT.

EMPLOYEE:	BRETZ, ROBERT L.	
	BOX 1553	
	809 S. 16TH AVE.	
	YAKIMA	WA 99902
EMPLOYER:	ALASKA LUMBER AND PULP	
	BOX 1050	
	SITKA	AK 99835
INJURY DATE:	04/24/82	
ANCB CASE NO:	206809	
REF YOUR CLAIM	100313	

VERY TRULY YOURS,

~~J. PAUL HOUSE~~, ADMINISTRATOR
SECOND INJURY FUND
Elaine VanderSande, jt

FORM NO. 6104R

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

Robert L. Bretz Employee,

vs.

Alaska Lumber and Pulp. Employer,

and

Scott Wetzel Services Insurers, Defendants.

AFFIDAVIT

Case No. AWCB 206809

State of Alaska)
) ss.
First Judicial District)

Elaine VanderSande, being first duly sworn, says:

1. I am an employee of the State of Alaska, Division of Workers' Compensation.

2. I have reviewed our records for the above captioned case and find the compensation report for the payment made through 5/7/83 was postmarked 4/9/84 and received 5/9/84 in Juneau Alaska.

Elaine VanderSande

Elaine VanderSande

Subscribed and sworn to before me this 19th day of September 1984, in Juneau, Alaska.

Patricia A. Shaw

Notary Public for Alaska.

My commission expires 6-21-87

07-GGLH

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY.
READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 206809

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
BRETZ, ROBERT	100313	4 / 24 / 82

AWCB MAY 29 1984 APR 11 1984 4/9/84 P

4. Address	5. Social Security Number
809 South 16th Avenue	532-44-3962
City, State, Zip, Telephone: Yakima, Washington 98902	6. Birthdate: 7 / 23 / 48

7. Employer	8. Insurer/Adjusting Company
ALASKA PULP AMERICA, INC.	SELF-INSURED c/o SCOTT WETZEL SERVICES
9. Address: P.O. Box 1050	10. Address: 741 Sesame Street, Suite 1A
City, State, Zip, Telephone: Sitka, Alaska 99835 747-2216	City, State, Zip, Telephone: Anchorage, Alaska 99503 561-1725

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: ____ / ____ / ____ Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? ____

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured. ____

14. RATE S	15. HOW RATE WAS FIGURED			
☐ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages: S	Employee Avg. Wk. Wage: ÷ 52 weeks = S	Alaska Weekly Rate: X 66 2/3% = S	Alaska Max. or Min.: S
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage: S	Earning Capacity: −S	Difference: =S	Alaska Weekly Rate: X 66 2/3% = S	Alaska Max. or Min.: S
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage: S	Alaska Avg. Wk. Wage: ÷S	State Ratio: = %	Alaska Weekly Rate: X S	State Weekly Rate: = S

(1) State or Country ____ (2) Date Left ____ / ____ / ____ (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☒ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: ____ / ____ / ____ ☐ h. ANNIVERSARY ☒ i. OTHER (Explain) SIF Payment

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
	TTD	4/25/82	6/8/82	6 3	S 481.95	S 3,098.25
	TTD	6/9/82	12/31/82	29 3	S 304.11	S 8,949.51
5/16/83	TTD	1/1/83	5/7/83	18 1	S 313.75	S 5,692.32
					S	S
					S	S
					S	S

(If additional space is needed, use chart on reverse.) TOTAL S 17,740.08

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? ____

20. a. Date Disability Began	4 / 25 / 82	22. a. Employee Attorney Fees	S [illegible]	b. Late Report Penalties	S
b. First Payment Date	5 / 7 / 82	c. Employer Attorney Fees	S 721.24	d. Medical	S 5,364.20
21. Date Disability Ended	see remarks	e. Second Injury Fund	S 1,064.40	f. Rehabilitation	S
		☒ $1,064.40 Check to SIF Attached		g. Other	S

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work ____ / ____ / ____ Date ☐ At New Job ☐ At Same Job	24. ☒ Released for Work Date 3/ 21/83	25. ☐ Moved from Alaska	26. ☐ Compromise and Release
Occupation ____	☐ Regular Work	27. ☐ Returned to Alaska	28. ☐ Controversion (Attach 07-6105)
Weekly Pay Rate S ____	☐ Modified Work	29. ☐ Recomputation	30. ☐ Board Order
		31. ☐ Other	32. ☐ Lack Recent Medical Report

33. Remarks: CONTROVERTED 5/6/83. **ACTUAL PAID TTD $24,364.20. OVERPAYMENT OF $6,624.12.

cc: AWCB
AL&P
File cc: Tom Bachelor, Attny.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
JULIA FALKE, CLAIM EXAMINER	[signature]	4 / 9 / 84

37. Address (If different from No. 10) ____ City ____ State ____ Zip ____ Telephone ____

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number:

1. Employee's Name (Last, First, Middle Initial): BRETZ, ROBERT
2. Insurer Claim Number: 100313
3. Injury Date: 4 / 24 / 82
4. Address: 809 SOUTH 16th AVE.
City: YAKIMA State: WA Zip: 98902 Telephone:
5. Social Security Number: 532 - 44 - 3062
6. Birthdate: 7 / 23 / 48
7. Employer: ALASKA PULP CORPORATION
8. Insurer/Adjusting Company: SELF INSURED
9. Address: P.O. BOX 1050
City: SITKA State: AK Zip: 99835 Telephone:
10. Address: SCOTT WETZEL SERVICES
City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years. 19 ____ Documents received: / / (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $

15. HOW RATE WAS FIGURED

	a. Gross Wages	Employee Avg. Wk. Wage	Alaska Weekly Rate	Alaska Max. or Min.
☐ a. Alaska TTD, PTD, death or scheduled PPD	$	÷ 52 weeks = $	X 66 2/3% = $	$
	b. Employee Avg. Wk. Wage	Earning Capacity	Difference	Alaska Weekly Rate	Alaska Max. or Min.
☐ b. Alaska unscheduled PPD or TPD	$	−$	= $	X66 2/3%= $	$
	c. State Avg. Wk. Wage	Alaska Avg. Wk. Wage	State Ratio	Alaska Weekly Rate	State Weekly Rate
☐ c. Out-of-state TTD, TPD, PPD, PTO or death	$	÷ $	= %	X $	= $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☒ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☒ g. RESUMPTION Knowledge Date: 9 / 4 / 84 ☐ h. ANNIVERSARY ☐ i. OTHER (Explain) C+R

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
	TTD	4-25-82	6-08-82	6 3	$ 481.95	$ 3,098.25
	TTD	6-09-82	12-31-82	29 3	$ 304.11	$ 8,949.51
	TTD	1-01-83	5-07-83	18 1	$ 313.75	$ 5,692.32
9-7-84	PER COMPROMISE AND RELEASE APPROVED 8-31-84 BY AWCB					$ 15,795.22
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 33,535.30

18. Impairment Rating: ____% of ____ ; ____% of ____ ; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 4 / 25 / 82
b. First Payment Date 5 / 7 / 82
21. Date Disability Ended 5 / 7 / 83

22. a. Employee Attorney Fees $ ____ b. Late Report Penalties $ ____
c. Employer Attorney Fees $ ____ d. Medical $ 5,564.20
e. Second Injury Fund $ 9,011.51 ☐ s947.11 Check to SIF Attached f. Rehabilitation $ ____
g. Other $ ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work / / (Date) ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate $ ____
24. ☐ Released for Work Date / /
☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks:
CC: FILE AWCB ALEp/PAT 6,624.12 portion of 15,795.22 constitutes overpayment. Actual paid to Employee per CTE is $9,161.10

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

34. Name and Title of Person Submitting Report (Type or Print): TERRA FALKE/CLAIMS EXAMINER
35. Signature: Terra Falke
36. Date: 9/11/84
37. Address (If different from No. 10) City State Zip Telephone

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 206809

1. Employee's Name (Last, First, Middle Initial): Bretz, Robert
2. Insurer Claim Number: 100313
3. Injury Date: 04 / 22 / 82
4. Address: 809 South 16th Ave.
City: Yakima State: Washington Zip: 98902 Telephone:
5. Social Security Number: 532 - 44 - 3962
6. Birthdate: 07 / 27 / 48
7. Employer: Alaska Pulp America, Inc
8. Insurer/Adjusting Company: Self Insured
9. Address: P. O. Box 1050
City: Sitka State: AK Zip: 99835 Telephone:
10. Address: c/o Scott Wetzel Services
City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: / / Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE S

15. HOW RATE WAS FIGURED

☐ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages	Employee Avg. Wk. Wage	Alaska Weekly Rate	Alaska Max. or Min.
	S	÷ 52 weeks = S	X 66 2/3% = S	
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage	Earning Capacity	Difference	Alaska Weekly Rate / Alaska Max. or Min.
	S	-S	=S X 66 2/3% = S	
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage	Alaska Avg. Wk. Wage	State Ratio	Alaska Weekly Rate / State Weekly Rate
	S	÷ S	= % X S	

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☒ i. OTHER (Explain) Compromise & Release

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
	TTD	4/25/82	6/12/82	6 2	S 421.95	S 2,953.65
	TTD	6/19/82	12/31/82	29 2	S 306.11	S 9,180.51
5/4/83	TTD	1/1/83	5/7/83	18 1	S 313.75	S 5,650.50
					S	S
					S	S
					S	S

(If additional space is needed, use chart on reverse.) TOTAL S 17,784.66

18. Impairment Rating: ____% of ____; ____% of ____; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 4/25/82
b. First Payment Date 5/7/82
21. Date Disability Ended 5/6/83 (Last Day)

22. a. Employee Attorney Fees S ____ b. Late Report Penalties S ____
c. Employer Attorney Fees S ____ d. Medical S ____
e. Second Injury Fund S 1,000.00 f. Rehabilitation S ____
☐ Check to SIF Attached g. Other S ____

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☐ Returned to Work / / Date ☐ At New Job ☐ At Same Job
Occupation ____
Weekly Pay Rate S ____
24. ☒ Released for Work Date 3/21/83
☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks:

Controverted 5/6/83. Actual Paid TTD 24,364.20 Overpayment of 6,624.12.

cc: File AWCB AI. & P/Pat

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print): Julia Falke Claims Examiner
35. Signature: Julia A. Falke
36. Date: 05 / 16 / 84

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. FOR INFORMATION ONLY. READ IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 206809

1. Employee's Name (Last, First, Middle Initial): BRETZ, ROBERT
2. Insurer Claim Number: 100313
3. Injury Date: 4/ 24 /82
4. Address: 809 South 16th Avenue
City: Yakima, State: Washington, Zip: 98902, Telephone:
AWCB APR 11 '84 4/9/84 P
5. Social Security Number: 532-44-3962
6. Birthdate: 7 / 23 /48
7. Employer: ALASKA PULP AMERICA, INC.
8. Insurer/Adjusting Company: SELF-INSURED c/o SCOTT WETZEL SERVICES
9. Address: P.O. Box 1050
City: Sitka, State: Alaska, Zip: 99835, Telephone: 747-2216
10. Address: 741 Sesame Street, Suite 1A
City: Anchorage, State: Alaska, Zip: 99503, Telephone: 561-1725

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: / / (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $

15. HOW RATE WAS FIGURED

☐ a. Alaska TTD, PTD, death or scheduled PPD — a. Gross Wages $ ÷ 52 weeks = $ Employee Avg. Wk. Wage $ × 66⅔% = $ Alaska Weekly Rate; Alaska Max. or Min. $

☐ b. Alaska unscheduled PPD or TPD — b. Employee Avg. Wk. Wage $ − Earning Capacity $ = Difference $ × 66⅔% = $ Alaska Weekly Rate; Alaska Max. or Min. $

☐ c. Out-of-state TTD, TPD, PPD, PTD or death — c. State Avg. Wk. Wage $ ÷ Alaska Avg. Wk. Wage $ = State Ratio % × Alaska Weekly Rate $ = State Weekly Rate $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☒ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain) SIF Payment

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
	TTD	4/25/82	6/8/82	6 3	$ 481.95	$ 3,098.25
	TTD	6/9/82	12/31/82	29 3	$ 304.11	$ 8,949.51
5/1/83	TTD	1/1/83	5/7/83	18 1	$ 313.75	$ 5,692.32
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 17,740.08

18. Impairment Rating: ____% of ____ ____% of ____ ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 4 / 25 / 82
b. First Payment Date 5 / 7 / 82
21. Date Disability Ended see remarks

22. a. Employee Attorney Fees $
b. Late Report Penalties $
c. Employer Attorney Fees $ 721.24
d. Medical $ 5,364.20
e. Second Injury Fund ☒ $1,064.40 Check to SIF Attached
f. Rehabilitation $
g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

22. ☐ Returned to Work / / (Date) ☐ At New Job ☐ At Same Job
Occupation
Weekly Pay Rate $

24. ☒ Released for Work Date 3/ 21/83
☐ Regular Work ☐ Modified Work

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other

26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks:
CONTROVERTED 5/6/83. **ACTUAL PAID TTD $24,364.20. OVERPAYMENT OF $6,624.12.

cc: AWCB
AL&P
File
cc: Tom Bachelor, Attny.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board

34. Name and Title of Person Submitting Report (Type or Print): JULIA FALKE, CLAIM EXAMINER
35. Signature: Julia Falke
36. Date: 4 / 9 / 84

37. Address (If not as shown in 10)

STATE OF ALASKA

DEPARTMENT OF LABOR

BILL SHEFFIELD, GOVERNOR

BOX 1149
JUNEAU, ALASKA 99811
PHONE: 465-2790

TO: Julie Falke
Scott Wetzel
Anch, AK

Date 4-20-84

Dear Insurer:

I. _____ According to AS 23.30.155(a),(c), and (e), compensation payments must be made within 14 days after payment is due unless timely controverted or late payment resulted from conditions beyond your control. Your recent Compensation Report for the case captioned below indicates the payment you made _______________, 1982 was later than 14 days after due.

If you dispute this determination, please advise the reasons why the penalty should be excused. If you do not dispute it, please pay the injured worker 20% of each late installment of compensation and file a compensation report showing that payment.

II. _____ The compensation report for the payment you made _______________, 1982 contained the following error(s) or ommission(s):

_____ Items 1 - 10 _____ Items 18 - 19

_____ Items 11 - 13 _____ Items 20 - 21

_____ Item 14 - 15 _____ Items 23 - 32

_____ Item 17 _____ Items 33 - 35

Please correct the(se) error(s) or ommission(s) and attach this letter to your corrected report when it is resubmitted.

Employee Root, Robert Insurer No. 100.313

Employer Alaska Rubber Co. AWCB No. 206.80

Date of Injury 9-21-84-80

Very truly yours,

Pat Shura
Workers' Compensation Division

Termination report & Payment date

AN ~~INITIAL~~ REPORT HAS NOT BEEN RECEIVED ON THIS CLAIM. PLEASE PROVIDE THE INITIAL REPORT. IF YOU PREVIOUSLY MAILED THE REPORT REQUESTED, PLEASE FILE AN AFFIDAVIT WITH THE REPORT TO PREVENT A LATE REPORTING PENALTY.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
P.O. Box 1149, Juneau, Alaska 99811

NOTICE TO CONTROVERT PAYMENT OF BENEFITS

AWCB Case No. 2C 5.09

This form is required if the employer/insurer desires to controvert payment of benefits.
Complete and mail the original to the employee with a copy to the Alaska Workers' Compensation Board.

Employee Name (last, First, Middle Initial)	Insurer Claim Number	Alleged Date of Injury
Bretz, Robert	100313	4/24/82
Address	**Date of Employer's First Knowledge**	**Social Security Number**
Box 1553	4/24/82	532-44-2962
City / State / Zip Code / Telephone		**Date of Birth**
Sitka AK 99835		4/5/[illegible]
Employer	**Insurer**	
Alaska Pulp Corporation	Seattle Mutual Insurance	
Address	**Address**	
P O Box 1050	P O Box 2559	
City / State / Zip Code / Telephone	**City / State / Zip Code / Telephone**	
Sitka Alaska 99835	Juneau AK 99803	586-2051

Nature of Alleged Injury or Illness:
Low back strain

Under the provisions of AS 23.30.155 the employer insurer gives notice that the right to the benefit(s) described below is controverted on the following grounds:

Type of Benefits Controverted	Reason for Controverting - State specific reasons and describe evidence relied upon and not merely conclusions. The controversion must show valid factual or legal objections to the payment of benefits. (Note: Failure to state specific reasons may result in this notice being declared invalid.)
☐ Entire Claim Denied on the issue of Compensability	**Reason Entire Claim Controverted:**
Specific Benefits Controverted	**Reason Specific Benefit Controverted**
TTD benefits after 5-7-83	Claimant released for unrestricted work, modifications to [illegible] by employer, claimant failed to mitigate damages [illegible] to report to employer for Return to work.

This is to certify that the original notice and compensation report (form 07-6105) have been mailed to the employee at the above address and a copy has been mailed to the Alaska Workers' Compensation Board.

Prepared By (Signature)	Title	Date
Cathy Eaton	Claim Manager	5/16/83
Company Name	**Address / City / State / Zip Code**	
Seattle Mutual Insurance	P O Box 2559 Juneau AK 99803	

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case No. 296509

1. Employee's Name (last, first, middle initial)	2. Insurer Claim No.	3. Injury Date
Bfetz, Robert	100313	4 24 82

4. Address	5. Social Security No.
P.O. Box 1553	532 44 3962
City: Sitka, State: Ak., Zip: 99835, Telephone:	6. Birthdate: 7 / 23 / 48

7. Employer	8. Insurer
Alaska Lumber & Pulp Co., Inc.	Scott Wetzel Services, Inc.
9. Address: P.O. Box 1050	10. Address: P. O. Box 2559
City: Sitka, State: , Zip: , Telephone: 747-2216	City: Juneau, Alaska State: 99803 Zip: Telephone: 789-3081

COMPENSATION RATE (Complete for initial payment or rate change.)

11. METHOD:
- ☐ 1. Awaiting gross wage documentation
- ☑ 2. Highest of three years, 19 81
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If Method 3, 4, or 5, explain:

13. Board, rent, housing, similar advantage included? ☐ No ☐ Yes. If yes, how computed?

14. RATE: $ 313.75

15. COMPUTATION

☒ Alaska TTD, PTD, death, or scheduled PPD	Gross Wages $ 37,590.30	÷ 52 weeks = $	Employee Ave. Wk. Wage 722.89	X 66-2/3% = Alaska Weekly Rate $ 481.95
☐ Alaska unscheduled PPD or TPD	Employee Ave. Wk. Wage $	—	Earning Capacity $	X 66-2/3% = Alaska Weekly Rate $
☒ Out-Of-State TTD, TPD, PPD, PTD or death	State Ave. Wk Wage $ 297 / 324	÷ $	Alaska Ave. Wk. Wage 471 / 498 =	Alaska Weekly Rate .631 / % X $ 651 = State Weekly Rate $ 304.11 (X2) / $ 313.75

Specify State or Country: Washington Date Moved: 6 9 82

16. ☐ INITIAL PAYMENT ☒ RATE CHANGE ☐ SUSPENSION* ☐ RESUMPTION ☐ TERMINATION*
☐ ANNIVERSARY** ☐ TYPE CHANGE ☐ OTHER (Explain)

17. Payment Date	Type***	From	Through	Weeks & Days	Rate	Total Amount
	TTD	4 25 82	6 8 82	6 3	$ 481.95	$ 3,098.25
4 7 83	TTD	6 9 82	12 31 82	29 3	$ 304.11	$ 8,949.52
4 7 83	TTD	1 1 83			$ 313.75	$
					$	$
					$	$
					$	$

(If additional space needed, use chart on reverse.) TOTAL $

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. Was permanent disability compensation paid in a lump sum? ☐ No ☐ Yes (Enter Amount Above.)
If yes, how computed?

20. Date Disability Began: 4 25 82 21. Date Disability Ended:

22. Employee Attorney Fees $	Late Report Fines $	Medical $ 3,759.03
Employer Attorney Fees $	Second Injury Fund $	Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NONPAYMENT

23. Returned to work ____ Date
- ☐ At Same Job
- ☐ At New Job
- Occupation
- Weekly Pay Rate $

24. ☐ Released for Work
- ☐ Regular Work
- ☐ Modified Work
- Date:

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other (Explain)

26. ☐ Compromise & Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order

32. REMARKS: Clmt. has been ~~xxxx~~ overpaid $7,001.91 because we paid at Alaska Rate from 6/9/82 - 3/26/83 when he was living in Washington. We have adjusted to approp. out of State rate and are taking a 20% offset until we recover the overpayment.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

33. Name & Title of Person Submitting Report (Type or Print)	34. Signature	35. Date
Betty Sexton, Claim Manager	Betty Sexton	4 8 83

36. Address	City	State	Zip Code	Telephone
AWS	PO Box 2559	Juneau	AK 99803	789-3037

EMPLOYEE: THE BACK OF THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS. PLEASE READ IT.

Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

1. Employee's Name (last, first, middle initial)	2. Insurer Claim No.	3. Injury Date
Bretz, Robert	100313	4-24-82

4. Address	5. Social Security No.
Box 1553	532 / 44 / 3962

City	State	Zip	Telephone	6. Birthdate
Sitka	AK	99835	747-8552	7 / 23 / 48

7. Employer	8. Insurer
Alaska Lumber & Pulp Co., Inc.	Scott Wetzel Services, Inc. (administrator)

9. Address	10. Address
P.O. Box 1050	P.O. Box 2559

City	State	Zip	Telephone	City	State	Zip	Telephone
Sitka, AK	99835		747-2217	Juneau	AK	99803	789-30

COMPENSATION RATE (Complete for initial payment or rate change.)

11. METHODS:
- ☐ 1. Awaiting gross wage documentation
- ☒ 2. Highest of three years, 19 81
- ☐ 3. Same or similar wages
- ☐ 4. Minor apprentice
- ☐ 5. Volunteer policeman, etc.

12. If Method 3, 4, or 5, explain:

13. Board, rent, housing, similar advantage included?
☐ No ☐ Yes. If yes, how computed?

14. RATE: $ 481.95

15. COMPUTATION

☐ Alaska TTD, PTD, death, or scheduled PPD	Gross Wages $ 37,590.30	÷ 52 weeks = $	Employee Ave. Wk. Wage 722.89	X 66-2/3% = Alaska Weekly Rate $ 481.95
☐ Alaska unscheduled PPD or TPD	Employee Ave. Wk. Wage $	−	Earning Capacity $	X 66-2/3% = Alaska Weekly Rate $
☐ Out-Of-State TTD, TPD, PPC, PTD or death	State Ave. Wk Wage $	÷ Alaska Ave. Wk. Wage $	= % X Alaska Weekly Rate $	State Weekly Rate $

Specify State or Country: Date Moved:

16. ☒ INITIAL PAYMENT ☐ RATE CHANGE ☐ SUSPENSION* ☐ RESUMPTION ☐ TERMINATION*
☐ ANNIVERSARY** ☐ TYPE CHANGE ☐ OTHER (Explain)

17. Payment Date	Type***	From	Through	Weeks & Days	Rate	Total Amount
5-7-82	TTD	4-26-82			$ 481.95	$
					$	$
					$	$
					$	$
					$	$
					$	$
(If additional space needed, use chart on reverse.)					TOTAL	$

18. Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

19. Was permanent disability compensation paid in a lump sum? ☐ No ☐ Yes (Enter Amount Above.)
If yes, how computed?

20. Date Disability Began: 4-25-82 21. Date Disability Ended:

22. Employee Attorney Fees $	Late Report Fines $	Medical $
Employer Attorney Fees $	Second Injury Fund $	Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NONPAYMENT

23. Returned to work ____ Date
- ☐ At Same Job
- ☐ At New Job
  - Occupation ____
  - Weekly Pay Rate $ ____

24. ☐ Released for Work
- ☐ Regular Work
- ☐ Modified Work
  - Date: ____

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other (Explain) ____

26. ☐ Compromise & Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order

32. REMARKS:

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

33. Name & Title of Person Submitting Report (Type or Print)	34. Signature	35. Date
Karen M. West, Claims Assistant	Karen M. West	5-7-82

36. Address	City	State	Zip Code	Telephone
P.O. Box 2559	Juneau	AK	99803	789-3081

EMPLOYEE: THE BACK OF THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS. PLEASE READ IT.
Explanations and instructions on back.

Form 07-6104 (Rev. 6/81)

CRAWFORD & COMPANY

Insurance Adjusters

BUD AUFDERMAUER,
MANAGER

TELEPHONE (907) 276-3336

3300 ARCTIC BLVD., SUITE 101
ANCHORAGE, ALASKA 99503

September 17, 1982

J. PAUL HOUSE, ADMINISTRATOR
SECOND INJURY FUND
STATE OF ALASKA, DEPT. OF LABOR
Post Office Box 1149
Juneau, Alaska 99811

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

RE: Case No: 211597
Insured: HALLIBURTON SERVICES
Employee: Larry W. Middleton
Accident: June 6, 1982
Our File: 126-75747-B

Dear Mr. House:

Your letter of September 3, 1982 arrived in our office on the 8th prompting a review of this file. The department of Labor intends to assess a penalty of $325.00 in this case for failure to comply with Sec. 155 (c). That section of the act indicates a $100. fine and an additional penalty of $25.00 daily for failure to notify the Workmen's Compensation Board within 14 days of commencement of payment of benefits on form 07-6104.

In the case at hand, the employee is recovering out of the State of Alaska and is not a resident. The employer elected to pay a rate over and above that which calculations entitle the injured workman. The employee is receiving $319.06 weekly but is entitled to $212.51 per week. Overpayment of TTD will be adjusted from any eventual PPD. If no permanency occurs, the overpayment may be waived by the employer.

Concerning your penalty letter, our records indicate that the compensation report was mailed to the AWCB in Juneau on July 16, 1982 indicating first payment was made July 8 and continuing. Under Item #16, the small box for initial payment was not checked off.

Your date stamps from the AWCB indicate that the report was somehow received in your Anchorage office on July 26, 1982 and received in Juneau on July 28, 1982. Pat Shira then sent us form letter 07-G6LH under her date of July 30, 1982. Our date stamp indicates that we received this letter on August 2, 1982 and we returned it to Juneau that same date. The Board's next stamp date is August 6, 1982 so our mailing date of return on 8/2/82 is certainly realistic. We did not enter a date on the bottom line, probably because of our haste to return the form and because that typed line was a new addition to the form to which we were unaccustomed. We merely checked off in pen the initial payment square and returned the form.

We did not send the form to the Anchorage division and do not know why they received it first. Although it is going to be time and cost consuming, we are presently considering individually certifying every document mailed to the Board by this office.

Perhaps to adopt this practice, the necessity of future correspondence such as this will be eliminated.

So, to make the reading easier here:

7/16/82 - Report mailed to Juneau by Crawford
7/26/82 - Report Received AWCB Anchorage
7/28/82 - Report Received AWCB Juneau
7/30/82 - Report returned to Crawford
8/02/82 - Report received by Crawford & returned.
8/06/82 - Report received AWCB Juneau

Aside from the fact that I think it is absolutely ridiculous to reject a filing where a tiny box marked initial payment is not checked off when the filing is obviously a first payment, I would like to give you the opportunity to advise why the compensation report was sent to the Anchorage division and then returned to Juneau and then later returned to us for correcting.

The policing of the insurance industry by the Department of Labor is becoming intolerable to all carriers. The situation is becoming unhealthy and the wedge which has been driven in between the employee and carrier has not only increased the costs of handling claims but has established a distrustful attitude which is affecting us all. The local office of the AWCB is now verbally advising that they will require a sworn affidavit (reminding adjusters of the penalties of perjury) in cases where a compensation report has been mailed but has not appeared in Juneau. While there may be instances of injustices by carriers, I have not in the past twenty years with this office personally made such an observation.

Perhaps the similarity to an approaching oppressive standard will resolve in the future. I will look forward to your response.

Very truly yours,

CRAWFORD AND COMPANY

Marlene Wilkes

Marlene Wilkes, Adjuster

cc: Halliburton Services
Highlands Insurance Co.
Jay S. Hammond, Governor
Tom Fink, Gubernatorial Candidate
Bill Sheffield Gubernatorial Candidate
Dick Randolph Gubernatorial Candidate
Virginia Collins
Ken Moore, Insurance Commissioner

1. Employee's Name (last, first, middle initial)
MIDDLETON, LARRY W.

Address
Star Route #3

City | State | Zip | Telephone
Brownwood, texas 76801 646-9261

Employer
HALLIBURTON SERVICES, INC.

Address
P. O. Box 6287

City | State | Zip | Telephone
Anchorage, Alaska 99502 279-3444

Insurer Claim No.
82-00-C300269

AWCB AUG 06 1982
AWCB JUNEAU JUL 28 1982
JUNEAU

3. Injury Date
06/06/82

5. Social Security No.
459 / 70 / 6326

6. Birthdate
Age 36 / /

8. Insurer
HIGHLAND S INSURANCE COMPANY

10. Address
Cullen Center Bank Bldg

City | State | Zip | Telephone
Houston, Texas

COMPENSATION RATE (Complete for initial payment or rate change.)

METHOD:
☐ 1. Awaiting gross wage documentation
☒ 2. Highest of three years, 19 81
☐ 3. Same or similar wages
☐ 4. Minor or apprentice
☐ 5. Volunteer policeman, etc.

12. If Method 3, 4, or 5, explain:

13. Board, rent, housing, similar advantage included?
☐ No ☐ Yes. If yes, how computed?

RATE: $319.06

14. COMPUTATION

☐ Alaska TTD, PTD, death, or scheduled PPD
Gross Wages $ 31,481.42 ÷ 52 weeks = $ Employee Ave. Wk. Wage 605.41 X 66-2/3% = Alaska Weekly Rate $ 403.60

☐ Alaska unscheduled PPD or TPD
Employee Ave. Wk. Wage $ — Earning Capacity $ X 66-2/3% = Alaska Weekly Rate $

☐ Out-Of-State TTD, TPD, PPD, PTD or death
State Ave. Wk Wage $ ÷ Alaska Ave. Wk. Wage $ = % X Alaska Weekly Wage $ = State Weekly Rate $

Specify State or Country: TEXAS
Date Moved: 06/10/82

☒ INITIAL PAYMENT ☐ RATE CHANGE ☐ SUSPENSION* ☐ RESUMPTION ☐ TERMINATION*
☐ ANNIVERSARY** ☐ TYPE CHANGE ☐ OTHER (Explain)

Payment Date	Type***	From	Through	Weeks & Days	Rate	Total Amount
/08/82	TTD	06/27/82	Continuing	1	$ 319.06	$ 319.06
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space needed, use chart on reverse.) TOTAL $

Impairment Rating: ____ % of ____ ; ____ % of ____ ; ____ % of ____

Was permanent disability compensation paid in a lump sum? ☐ No ☐ Yes (Enter Amount Above.)

If yes, how computed? 1

Date Disability Began: 06/27/82

21. Date Disability Ended: Continuing

Employee Attorney Fees $ | Late Report Fines $ | Medical $

Employer Attorney Fees $ | Second Injury Fund $ | Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NONPAYMENT

Returned to work ____ Date
☐ At Same Job
☐ At New Job
Occupation
Weekly Pay Rate $

24. ☐ Released for Work
☐ Regular Work
☐ Modified Work
Date:

25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other (Explain)

26. ☐ Compromise & Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order

REMARKS: Employee continued on full salary through 06/26/82. Payments have commenced direct by Halliburton at a Texas Rate which may be adjusted in the future. Standard Non-Resident reduction formula was not used.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

Name & Title of Person Submitting Report (Type or Print)
MURLENE WILKES

34. Signature
Murlene G. Wilkes

35. Date
07/16/82

Address | City | State | Zip Code | Telephone
3300 Arctic Blvd., #101 Anchorage, Alaska 99503 276-3336

EMPLOYEE: THE BACK OF THIS FORM CONTAINS IMPORTANT INFORMATION ABOUT YOUR RIGHTS. PLEASE READ IT.
Explanations and instructions on back.

4

Form 07-6104 (Rev. 6/81)
Formerly ADL 110 & 120

RECD ANCHORAGE JUL 26 1982

JAY S. HAMMOND, GOVERNOR

7547-B

DEPARTMENT OF LABOR

BOX 1149
JUNEAU, ALASKA 99811
PHONE:

TO: Marlene Wilkes
CR + Co
Anch, AK

Date 7-30-82

AWC3 JUNEAU AUG 06 1982

Dear Insurer:

As 23.30.155(c) requires you to notify the Board within 14 days after making first payment or increasing, reducing, terminating, suspending, resuming or changing compensation rates or types. Your Compensation Report for the case captioned below regarding payment made _____, 1982 does not comply with AS 23.30.155(c) as:

I. ____ It was overdue. Accordingly, $_____ is due. Please send your check in that a Fund, P.O. Box 1149, Juneau, Alaska 99811

II. X You failed to complete the following:

____ Item 11	X Item 16
____ Item 12	____ Item 17
____ Item 14	____ Item 20
____ Item 15	

As a result of the failure to comply with AS 2: not timely and a penalty is due. The penalty rate of $25.00 per day until a report is filed 23.30.155(c).

If your report is attached, you may revise and resubmit. If your report is not attached, a new report must be completed and submitted. In either case, please attach this letter as well as your penalty check, payable to the Second Injury Fund, to the corrected report. The penalty is due through the date the corrected report is mailed to the Fund.

Employee Middleton, Larry W Insurer No. 82-00-C3F0969

Employer Halliburton Services AWCB No. [redacted]

Date of Injury 6-6-82

Very truly yours,

Pat Shrin
Alaska Workers' Compensation Division

late payment made 7-8-82
17 days late. 7-9-82 Time
9-25-82. 7-25-82 rec'd re
Sunday no penalty stats
7-27-82. Corrected
report received 8-6-82
7-27-82 Thru 8-5-82 =
10 days

DATE THE CORRECTED REPORT MAILED TO OUR OFFICE: _____

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LABOR

BOX 1149
JUNEAU, ALASKA 99811
PHONE:

September 3, 1982

Murlene Wilkes
Claims Department
Crawford & Company
3300 Arctic Blvd, Suite 101
Anchorage, AK 99503

Dear Ms. Wilkes:

Re: Larry W. Middleton vs. Haliburton Service Co.
D/A 6-6-82 Case No. 211597

On July 30, 1982, Pat Shira of this office returned to you a compensation report which had been received by us on July 28, 1982, along with a letter advising that the report had not been completed in compliance with A.S.23.30.155 and that late filing penalty was due the Second Injury Fund until the date the corrected report was mailed to our office. At the bottom of the Pat's letter a space was provided underlined in red, for you to insert the mailing date. The mailing date was not entered and for this reason the date we received the corrected report applies. Consequently, the report was 10 days late in reaching this office (see attached) and a penalty payment is due the Second Injury Fund in the amount of $325.00 in compliance with Sec. 155(c).

The statute makes no provision for our excusing late filing penalties, therefore, we will anticipate your payment of $325.00 being made within 14 days from the date of this letter or we have no alternative but to schedule this matter for hearing by the Workers' Compensation Board.

Very truly yours,

J. Paul House, Administrator
Second Injury Fund
Workers' Compensation Division

7-GGLH

SCOTT WETZEL SERVICES, INCORPORATED

AN AFFILIATE OF THE HOME GROUP INC

INTER OFFICE MEMORANDUM

TO	OFFICE	FILE NO
Randy Weddle		
FROM	OFFICE	
Renee Murray		
SUBJECT		DATE
Penalty Case	Lloyd Rice vs. Alaska Lumb er & Pulp	10/22/84

Randy,

Here is another penalty case and this is a little unique also. This was handled by our Juneau office.

No payment was ever made on this case until it was settled on a Compromise and Release and then it was paid in one lump sum. Our Juneau office did not file a Compensation Report, as far as I can tell, but, of course, all amounts paid were included in the Compromise and Release which the Board signed, so they obviously did have the figures at their disposal.

I guess this is one I think we should fight on principal. They are asking us to pay $1000.00 for not providing them with a form that contains the information they already had.

Sure, we were wrong - but does this minor infraction warrant a $1000.00 penalty - or any penalty, for that matter.

Thanks for handling this for us.

Renee Murray

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPARTMENT OF LABOR

DIVISION OF WORKERS' COMPENSATION

1111 WEST 8th, Rm 305
BOX 1149
JUNEAU, ALASKA 99802
PHONE: (907) 465-2790

October 17, 1984

Alaska Lumber and Pulp, Inc.
3000 Rainier Bank Tower
Seattle, WA 98101

Gentlemen:

Re: Lloyd M. Rice (deceased) vs. Alaska Lumber and Pulp, Inc.
D/A 4-20-79 or 6-68 Case No. 78-06-1945

On January 14, 1983 the Alaska Workers' Compensation Board approved a compromise and release in settlement of the above claim. Until that time, no benefits had been paid. The Alaska Workers' Compensation Act under AS 23.30.155(c) requires that a compensation report be filed concerning all payments made, and no such report has been filed in this case. That section also provides for penalty payable to the Second Injury Fund for failure to file the report timely.

Please file the necessary report and include the present maximum penalty for late filing of $1,000, or submit a copy of a previously completed report which you claim was provided timely, together with an affidavit stating the report was filed as required.

Very truly yours,

Elaine VanderSande

Elaine VanderSande
Workers' Compensation Officer
Second Injury Fund

cc: Scott Wetzel Services
741 Sesame Street, Suite 1A
Anchorage, AK 99503

07.GCLH

Scott Wetzel Services Incorporated
An Affiliate of The Home Group Inc
741 Sesame Street • Suite 1A • Anchorage, Alaska 99503
Phone: (907) 561-1725

March 17, 1983

Jacqueline McClintock, Director
Alaska Workers' Compensation Division
P. O. Box 1149
Juneau, AK 99811

Re: Penalties Assessed Under Section 23.30.155(c),
Alaska Workers' Compensation Act

Dear Jackie:

The purpose of this letter is to voice my concerns over what I consider to be excessive and unnecessary penalties which are being assessed under the above section of the Alaska Workers' Compensation Law.

First of all, let me assure you that I am fully cognizant of the fact that you are acting as directed by the law and that you have no choice in the matter. Therefore, my concern is with having the law changed because I feel it is unreasonable and requires excessive and redundant reporting and I object strongly to the policing action and the harassment.

The entire Workers' Compensation Act is a law which we obey simply because it is the law and we attempt to obey it to the best of our ability. We do this with or without the threat of any penalty.

Let me assure you that I have no objection to the filing of the Compensation Report. In fact, it is quite the contrary. I feel that it is necessary that you have this information and it is important to us as well as to the Division that the actual costs of all of our systems are known and retrievable, so we would file the report with or without the threat of any penalty as we do with all other forms which we are required to file.

Our firm has had to pay very few penalties, but that is not the issue. The issue is the constant harassment by the letters which are generated by the computer threatening us with huge penalties of anywhere from $100 to $2500 changed to $1000. the morale problem it has created with our staff, and the time that it takes to answer these numerous inquiries over nitpicky details and explain why we neglected or forgot to mark an "X" in a certain box which has caused us to be assessed a penalty of several hundred dollars. An example of this is attached hereto.

IN THIS CASE, YOU WILL NOTE THAT WE FILED OUR INITIAL REPORT AND WE FILED THE TERMINATION REPORT WHICH ALSO INCORPORATED A RATE CHANGE AND WE NEGLECTED TO MARK THE RATE CHANGE BOX. THE PROPER RATE WAS PAID, THE REPORT WAS TIMELY FILED BUT THE FAILURE TO MARK THIS BOX HAS GENERATED A $800 PENALTY LETTER, COPY ATTACHED.

I FEEL ABSOLUTELY CERTAIN THAT YOU WILL AGREE WITH ME THAT THIS IS WRONG AND THAT THIS WAS NEVER THE INTENT OF THE LAW; IT JUST HAPPENS TO BE THE END RESULT. I GUESS WHAT I'M REALLY OBJECTING TO IS THE BUREAUCRACY THAT THIS HAS CREATED AND ALL OF THE PAPERWORK, THE TIME, THE EXPENSE, THE AURA OF DISTRUST, THE REQUEST FOR AFFIDAVITS WHICH ARE A COMPLETE INSULT TO OUR HONESTY AND INTEGRITY AND THE FACT THAT THERE IS ARSOLUTELY NO ALLOWANCE FOR HUMAN ERROR.

IT GOES WITHOUT SAYING THAT THE PUNISHMENT IS EXCESSIVE AND DOES NOT FIT THE CRIME.

THIS LAW HAS CREATED IMMEASURABLE ADMINISTRATIVE EXPENSE WHICH OBVIOUSLY MUST BE PASSED ON TO OUR CLIENTS AND EVENTUALLY TO THE GENERAL PUBLIC AND CONSUMER, SO EVERYONE LOSES EXCEPT THE STATE OF ALASKA.

I REALIZE YOU ARE NOT RESPONSIBLE FOR THIS LAW BUT I ALSO REALIZE THAT YOU CAN BE QUITE EFFECTIVE IN HAVING THE NECESSARY CHANGES EFFECTED. THIS COULD EASILY BE REMEDIED BY REMOVING THE WORD "SHALL" ASSESS AND CHANGING IT TO "MAY" ASSESS. THEREFORE, I AM ASKING YOUR ASSISTANCE TO ACCOMPLISH THIS IN THE MOST EXPEDIENT AND REASONABLE MANNER.

THANK YOU SO MUCH FOR YOUR ASSISTANCE AND CONTINUED COOPERATION.

VERY TRULY YOURS,

SCOTT WETZEL SERVICES, INC.

Renee Murray

RENEE MURRAY
ALASKA MANAGER

RM/VP

CC: JIM ROBINSON, COMMISSIONER OF LABOR

STATE OF ALASKA
DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
P.O. BOX 1149
JUNEAU ALASKA 99811
(907) 465 2790

DATE 02/25/83

Paul
3-4-83

SCOTT WETZEL SERVICES
741 SESAME ST SUITE 1A
ANCHORAGE AK 99503

DEAR INSURER:

AS 23.30.155(C) REQUIRES YOU TO NOTIFY THE BOARD WITHIN 14 DAYS AFTER MAKING FIRST PAYMENT OR INCREASING, REDUCING, TERMINATING, SUSPENDING, RESUMING OR CHANGING COMPENSATION RATES OR TYPES.

YOUR COMPENSATION REPORT FOR THE CASE CAPTIONED BELOW REGARDING PAYMENT MADE 01/04/83, WAS 29 DAYS OVERDUE. ACCORDINGLY, $800 LATE REPORT PENALTY IS DUE. PLEASE SEND YOUR CHECK IN THAT AMOUNT TO THE SECOND INJURY FUND, P.O. BOX 1149, JUNEAU, AK 99811.

EMPLOYEE:	BAUER, STEPHAN	
	BOX 9	
	ILIAMNA	AK 99606
EMPLOYER:	WIEN AIR ALASKA	
	4100 INT'L AIRPORT RD.	
	ANCHORAGE	AK 99502
INJURY DATE:	12/09/82	
AWCB CASE NO:	226213	
REF YOUR CLAIM	794	

VERY TRULY YOURS,

Paul Howe

J. PAUL HOUSE, ADMINISTRATOR
SECOND INJURY FUND

FORM NO. 6104R

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. THIS IS INFORMATION ONLY. REAL IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number: 336313

1. Employee's Name (Last, First, Middle Initial): Brauer, Stephen
2. Insurer Claim Number: 794
3. Injury Date: 12 9 82
4. Address: Box 9
5. Social Security Number: 476-64-7033
City: Iliamna State: AK Zip: 99606 Telephone:
6. Birthdate: 5/29/54
7. Employer: Wien Air Alaska
8. Insurer/Adjusting Company: Self-Insured
9. Address: 4100 Int'l Airport Rd.
City: Anch State: AK Zip: 99502 Telephone:
10. Address (): 90 Scott Wilbur Services
City: State: Zip: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHODS
- ☐ 1. Awaiting gross wages documents
- ☒ 2. Highest of three years, 19 81 Documents received: 1/3/83 (Date)
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

13. ☐ Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $ 320.90

15. HOW RATE WAS FIGURED

☒ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $25,030.18	52 weeks = $ 481.35	Employee Avg. Wk. Wage	X 66 2/3% = $ 320.90	Alaska Weekly Rate / Alaska Max. or Min. $
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	−$	Earning Capacity =$	Difference X 66 2/3% = $	Alaska Weekly Rate / Alaska Max. or Min. $
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	÷ $	Alaska Avg. Wk. Wage = %	State Ratio X $	Alaska Weekly Rate / State Weekly Rate = $

(1) State or Country (2) Date Left / / (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☐ c. TERMINATION ☐ d. SUSPENSION ☒ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: / / ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
1-4-83	TTD	12-13-82	1-3-83	3 1	$ 320.90	$ 1003.54
					$	$
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 1003.54

18. Impairment Rating: ____% of ____ : ____% of ____ : ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 1/4/83
b. First Payment Date 12/25/82
21. Date Disability Ended 1/3/83

22. a. Employee Attorney Fees $ 0
b. Late Report Penalties $ 0
c. Employer Attorney Fees $ 0
d. Medical $ 1150.00
e. Second Injury Fund $ 100.51 ☐ $ Check to SIF Attached
f. Rehabilitation $ 0
g. Other $ 0

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☒ Returned to Work 1/4/83 (Date) ☐ At New Job ☒ At Same Job
Occupation
Weekly Pay Rate $
24. ☐ Released for Work Date / / ☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska
27. ☐ Returned to Alaska
29. ☐ Recomputation
31. ☐ Other
26. ☐ Compromise and Release
28. ☐ Controversion (Attach 07-6105)
30. ☐ Board Order
32. ☐ Lack Recent Medical Report

33. Remarks: CC: AWCB Wien File
Rate Change report only. Final filed 1/4/83. See ATTACHED.

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Julia Falke Claim Examiner	Julia Falke	2/18/83

37. Address (If different from No. 10) 7411 Sand Lake Cir. Ste. 1-A City: Anch. State: AK Zip: 99502 Telephone: 561-1775

EMPLOYEE: KEEP THIS REPORT FOR YOUR RECORDS. IT MAY BE REQUIRED LATER. READ THE BACK FOR ALL INFORMATION ABOUT YOUR RIGHTS OR DUTIES.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number:

1. Employee's Name (Last, First, Middle Initial)	2. Insurer Claim Number	3. Injury Date
Bauer, Heather	794	12/9/82
4. Address		**5. Social Security Number**
Box 9		476-60-7033
City / State / Zip / Telephone		**6. Birthdate**
Wainwright, AK 99782		5/29/54
7. Employer	**8. Insurer/Adjusting Company**	
Wien Air Alaska	Self-Insured	
9. Address	**10. Address**	
4100 International	c/o Scott Wetzel Services	
City / State / Zip / Telephone	**City / State / Zip / Telephone**	
Anch. AK 99502		

COMPENSATION RATE (Complete for initial payment or rate change)

11. METHOD
- [X] 1. Awaiting gross wages documents
- [ ] 2. Highest of three years, 19 ____
  Documents received: ____/____/____ (Date)
- [ ] 3. Same or similar wages
- [ ] 4. Minor or apprentice
- [ ] 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages? ____

[ ] 13. Tips, board, rent, housing or similar advantage included. Explain how figured. ____

14. RATE $ 65.00

15. HOW RATE WAS FIGURED

	a. Gross Wages	Employee Avg. Wk. Wage	Alaska Weekly Rate	Alaska Max. or Min.
[X] a. Alaska TTD, PTO, death or scheduled PPD	$	÷ 52 weeks = $	X 66 2/3% = $	$ 65 (Min)
[ ] b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity −$	Difference =$	X 66 2/3% = $
[ ] c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate X $ = $

(1) State or Country ____ (2) Date Left ____/____/____ (3) Were gross wages earned in Alaska? [ ] Yes [ ] No [ ] Partly

16. [X] a. INITIAL PAYMENT [ ] b. SIF PAYMENT ONLY [ ] c. TERMINATION [ ] d. SUSPENSION [ ] e. RATE CHANGE [ ] f. TYPE CHANGE
[ ] g. RESUMPTION Knowledge Date: ____/____/____ [ ] h. ANNIVERSARY [ ] i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
12/28/82	TTD	12/13/82			$ 65.00	$
					$	$
					$	$
					$	$
					$	$
					$	$
					TOTAL	$

(If additional space is needed, use chart on reverse.)

18. Impairment Rating: ____% of ____ : ____% of ____ : ____% of ____

19. [ ] Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it? ____

20. a. Date Disability Began 12/10/82
b. First Payment Date 12/28/82
21. Date Disability Ended ____/____/____

22. a. Employee Attorney Fees $ −0− b. Late Report Penalties $ −0−
c. Employer Attorney Fees $ −0− d. Medical $ −0−
e. Second Injury Fund $ −0− f. Rehabilitation $ −0−
[ ] SIF Check to SIF Attached g. Other $

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. [ ] Returned to Work ____/____/____ (Date) [ ] At New Job [ ] At Same Job
Occupation ____
Weekly Pay Rate $ ____
24. [ ] Released for Work Date ____/____/____
[ ] Regular Work [ ] Modified Work
25. [ ] Moved from Alaska
27. [ ] Returned to Alaska
29. [ ] Recomputation
31. [ ] Other
26. [ ] Compromise and Release
28. [ ] Controversion (Attach 07-6105)
30. [ ] Board Order
32. [ ] Lack Recent Medical Report

33. Remarks:

cc: AWCB + Wien Air AK

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Julia Falke, Claims Examiner	Julia Falke	12/28/82

37. Address (If different from No. 10) Scott Wetzel Services, 741 Sesame St. Anch. AK 99503 — City / State / Zip / Telephone

EMPLOYEE: RETURN REPORT FOR YOUR RECORDS. IMPORTANT INFORMATION ABOUT YOUR RIGHTS ON BACK. INFORMATION ONLY.

ALASKA DEPARTMENT OF LABOR
Alaska Workers' Compensation Board
Box 1149, Juneau, Alaska 99811

COMPENSATION REPORT

AWCB Case Number

1. Employee's Name (Last, First, Middle Initial): Bauer, Stephan
2. Insurer Claim Number: 794
3. Injury Date: 12/9/82
4. Address: Box 9
5. Social Security Number: 476-64-7033
City: Iliamna State: AK Zip: 99606 Telephone:
6. Birthdate: 5/29/54
7. Employer: Wien Air AK
8. Insurer/Adjusting Company: Self-Insured
9. Address: 4100 Int'l Airport Rd.
City: Anch. State: AK Zip: 99502 Telephone:
10. Address: c/o Scott Wetzel Services
City: State: Telephone:

COMPENSATION RATE (Complete for initial payment or rate change)

11 METHODS
- ☐ 1. Awaiting gross wages documents
- ☐ 2. Highest of three years, 19 ____ Documents received: ___/___/___ Date
- ☐ 3. Same or similar wages
- ☐ 4. Minor or apprentice
- ☐ 5. Volunteer policeman, etc.

12. If method 3, 4, or 5, how did you figure gross wages?

☐ 13. Tips, board, rent, housing or similar advantage included. Explain how figured.

14. RATE $

15. HOW RATE WAS FIGURED

☐ a. Alaska TTD, PTD, death or scheduled PPD	a. Gross Wages $	Employee Avg. Wk. Wage ÷ 52 weeks = $	Alaska Weekly Rate × 66 2/3% = $	Alaska Max. or Min. $
☐ b. Alaska unscheduled PPD or TPD	b. Employee Avg. Wk. Wage $	Earning Capacity −$	Difference =$	Alaska Weekly Rate × 66 2/3% = $	Alaska Max. or Min. $
☐ c. Out-of-state TTD, TPD, PPD, PTD or death	c. State Avg. Wk. Wage $	Alaska Avg. Wk. Wage ÷ $	State Ratio = %	Alaska Weekly Rate × $	State Weekly Rate = $

(1) State or Country (2) Date Left ___/___/___ (3) Were gross wages earned in Alaska? ☐ Yes ☐ No ☐ Partly

16. ☐ a. INITIAL PAYMENT ☐ b. SIF PAYMENT ONLY ☒ c. TERMINATION ☐ d. SUSPENSION ☐ e. RATE CHANGE ☐ f. TYPE CHANGE
☐ g. RESUMPTION Knowledge Date: ___/___/___ ☐ h. ANNIVERSARY ☐ i. OTHER (Explain)

17. a. Payment Date	b. Type	c. From	d. Through	e. Weeks & Days	f. Weekly Rate	g. Total Amount
1-4-83	TTD	12/13/82	1-3-83	3 1	$ 320.40	$ 1008.54
					$	$
					$	$
					$	$
					$	$
					$	$

(If additional space is needed, use chart on reverse.) TOTAL $ 1008.54

18. Impairment Rating: ____% of ____; ____% of ____; ____% of ____

19. ☐ Permanent disability compensation was paid in a lump sum. (Enter amount in No. 17.) How did you figure it?

20. a. Date Disability Began 12/10/82
b. First Payment Date 12/25/82
21. Date Disability Ended ___/___/___

22. a. Employee Attorney Fees $ 0 b. Late Report Penalties $ 0
c. Employer Attorney Fees $ 0 d. Medical $ 0
e. Second Injury Fund $ 60.51 f. Rehabilitation $ 0
~~$ 60.51~~ Check to SIF Attached g. Other $ 0

REASON FOR SUSPENSION, TERMINATION, RATE CHANGE, TYPE CHANGE, OR NON-PAYMENT

23. ☒ Returned to Work 1/4/83 Date ☐ At New Job ☒ At Same Job
Occupation ____ Weekly Pay Rate $
24. ☐ Released for Work Date ___/___/___ ☐ Regular Work ☐ Modified Work
25. ☐ Moved from Alaska 27. ☐ Returned to Alaska 29. ☐ Recomputation 31. ☐ Other
26. ☐ Compromise and Release 28. ☐ Controversion (Attach 07-6105) 30. ☐ Board Order 32. ☐ Lack Recent Medical Report

33. Remarks: cc: AWCB
Wien
File

I certify that I have mailed the original of this report to the employee at the address above and a copy to the Alaska Workers' Compensation Board.

34. Name and Title of Person Submitting Report (Type or Print)	35. Signature	36. Date
Julia Falke/Claim Examiner	Julia Falke	1/4/83

37. Address (If different from No. 10) 211 Seward St. Ste 1-A City: Anch. State: AK Zip: 99501 Telephone: 276-7111

Scott Wetzel Services Incorporated
An Affiliate of The Home Group Inc
741 Sesame Street • Suite 1A • Anchorage, Alaska 99503
Phone (907) 561-1725

February 13, 1984

Ms. Jacquelyn McClintock, Director
Alaska Worker's Compensation Division
P. O. Box 1149
Juneau, AK. 99811

Re: AWCB CASE NO: 204653
Employee: Kemo T. Crosby
Employer: Pacific Pearl Seafoods/AMFAC, Inc.
D.O.I. : 3/30/82

Dear Jackie:

Attached please find our Answer to the Petition of Readiness to Proceed filed by J. Paul House relative to the penalty for alleged late reporting.

Please schedule this for a formal hearing before the Worker's Compensation Board in Anchorage and also provide us with a copy of the Board's file so that we may know what information Mr. House is using as a basis for this alleged penalty.

Since it appears that all of the insurance carriers are receiving similar petitions, we would appreciate it if you would schedule all, or as many as possible, of these hearings on the same day. so that we may all set that time aside to be in attendance for this very important issue.

Your consideration to this request will be sincerely appreciated.

Very truly yours,

Renee Murray
Vice President

RM/bb

P.S. Jackie — Please note the affidavit that was filed on 2/2/84.
RM

Scott Wetzel Services Incorporated
An Affiliate of The Home Group Inc
741 Sesame Street • Suite 1A • Anchorage, Alaska 99503
Phone (907) 561-1725

FEBRUARY 1, 1984

J. PAUL HOUSE, ADMINISTRATOR
STATE OF ALASKA
SECOND INJURY FUND
P.O. BOX 1149
JUNEAU, AK 99802

RE: EMPLOYEE: KEMO T. CROSBY
EMPLOYER: AMFAC
DATE OF INJURY: 3/30/82
CLAIM NUMBER: 5870
AWCB NUMBER: 204653

DEAR MR. HOUSE:

I AM IN TOTAL DISAGREEMENT WITH YOUR LETTERS OF JANUARY 12, 1984 AND JANUARY 25, 1984.

AS YOU ARE AWARE, THE LAST TEMPORARY TOTAL DISABILITY PAYMENT MADE WAS JUNE 30, 1982, FOR THE PERIOD OF 6/23/83 THROUGH 7/6/83, WITH THE UNDERSTANDING FROM DR. FROST OF 6/30/83 THAT THE CLAIMANT WAS NOT RELEASED TO RETURN TO WORK. ON JULY 10, 1983, DR. FROST'S REPORT WAS RECEIVED INDICATING THAT MR. CROSBY HAS BEEN RELEASED TO RETURN TO WORK ON JULY 1, 1983. A TERMINATION REPORT WAS FILED ON JULY 20, 1983, TEN DAYS AFTER OUR KNOWLEDGE THAT MR. CROSBY HAD BEEN RELEASED TO RETURN TO WORK. I DO NOT SEE WHERE THE $225.00 IS DUE.

ENCLOSED IS MY AFFIDAVIT FOR YOUR RECORD.

VERY TRULY YOURS,

SCOTT WETZEL SERVICES, INC.

MARION BERRY
CLAIM EXAMINER

MB/BB

ENCLOSURE

CC: AWCB

SCOTT WETZEL SERVICES, INC.
741 SESAME STREET, SUITE 1A
ANCHORAGE, ALASKA 99503

STATE OF ALASKA)
) ss.
THIRD JUDICIAL DISTRICT)

KEMO CROSBY,
EMPLOYEE,

VS.

PACIFIC PEARL SEAFOODS,
EMPLOYER,

AND

SELF-INSURED,

SCOTT WETZEL SERVICES, ADJUSTER
DEFENDANTS.

AFFIDAVIT

CASE NUMBER: 204653

MARION C. BERRY, BEING FIRST DULY SWORN, SAYS:

1. I AM AN EMPLOYEE OF SCOTT WETZEL SERVICES, HERE IN ANCHORAGE, ALASKA.

2. THE LAST COMPENSATION PAYMENT MADE TO THE EMPLOYEE, MR. KEMO CROSBY, WAS ISSUED ON 6/30/83 FOR TEMPORARY TOTAL DISABILITY FROM 6/23/83 THROUGH 7/6/83, WHICH GENERATED FROM A TELEPHONE CALL TO DR. JOHN FROST OF ANCHORAGE, ALASKA ON 6/30/83, STATING MR. CROSBY WAS NOT RELEASED TO RETURN TO WORK.

3. ON 7/10/83, DR. JOHN FROST'S PHYSICIAN'S REPORT RECEIVED AT SCOTT WETZEL SERVICES, ANCHORAGE OFFICE, INDICATED KEMO CROSBY WAS RELEASED TO RETURN TO WORK ON 7/1/83.

4. ON 7/20/83 A TERMINATION REPORT WAS FILED, SHOWING AN OVERPAYMENT ON TEMPORARY TOTAL DISABILITY BENEFITS.

MARION C. BERRY

SUSCRIBED AND SWORN TO BEFORE ME THIS 2 DAY OF February, 1984, IN ANCHORAGE, ALASKA.

NOTARY PUBLIC FOR ALASKA

MY COMMISSION EXPIRES ON April 3, 1985.

ALASKA WORKERS' COMPENSATION BOARD
P.O. Box 1149 Juneau, Alaska 99811

IN THE MATTER OF THE CLAIM FOR COMPENSATION AND/OR BENEFITS UNDER THE ALASKA WORKERS' COMPENSATION ACT.

KEMO CROSBY
Employee,

vs.

PACIFIC PEARL SEAFOODS/AMFAC
Employer,

and

SCOTT WETZEL SERV ICES, INC.
, its Workers' Compensation ~~Insurance Carrier~~ Claims Administrator.

Case No. 204653

Second Injury Fund's
ANSWER TO ~~EMPLOYEE'S~~
APPLICATION FOR BENEFITS

The employer and its workers' compensation carrier admit the following portions of the ~~employee's~~ SECOND INJURY FUND'S claim filed on _____.

_____ Temporary Total Disability - From ____ through ____ From ____ through ____

_____ Temporary Partial Disability - From ____ through ____

_____ Permanent Total Disability - From ____ through ____

_____ Permanent Partial Disability - From ____ through ____

_____ Medical Costs - _____

_____ Compensation Rate (Average Weekly Wage Adjustment - _____

_____ Other - _____

The employer disputes the following claims made by the ~~employee~~ SECOND INJURY FUND on _____.

_____ Temporary Total Disability - From ____ through ____ From ____ through ____

_____ Temporary Partial Disability - From ____ through ____

_____ Permanent Total Disability - From ____ through ____

_____ Permanent Partial Disability - From ____ through ____

_____ Medical Costs - _____

_____ Compensation Rate (Average Weekly Wage Adjustment - _____

XX Other - Penalty for Late Reporting

There ~~is~~/is not a reason the case cannot be heard completely at the first hearing. The reason the case cannot be heard completely at the first hearing is _____

_____

_____

_____.

_____ The claim is/is not barred under AS 23.30.100, AS 23.30.105, or otherwise barred by law or equity.

_____ The injury was occasioned by the willful intention of the employee to injure or kill himself or another.

_____ The injury was occasioned by the intoxication of the employee.

_____ The last injurious exposure rule is or may be applicable to this claim.

_____ The employee has failed to mitigate his/her injuries. (State specific allegations.) _____

_____

_____

_____.

_____ The employee has been overpaid/paid at a different rate than that to which the employee is or may be entitled.

__x__ The employee's compensation rate should be adjusted for out-of-state residency under AS 23.30.175(d)&(e).

_____ Other: _____

_____

_____

_____.

DATED this 13 day of Feb, 1984.

SCOTT WETZEL SERVICES, INC.

By: Renee Murray
Renee Murray
Alaska Manager

I hereby certify that a true and correct copy of the foregoing was mailed this 13 day of Feb, 1984, to:
Jacquelyn McClintock, Director
Alaska Worker's Compensation Division
and Paul House - Second Injury Fund
and AMFAC, Inc.

_____

SCOTT WETZEL SERVICES, INC.
AN AFFILIATE OF THE HOME GROUP INC

SPEED MEMO

TO OFFICE	
Jacqueline McClintock	
FROM OFFICE	FILE NO.
Renee Murray	304304
SUBJECT	DATE
Compensation Reports Garnand vs. Wien Air	7/6/83

Dear Jackie:

I know you still don't understand my displeasure with the Compensation Report system, but maybe the attached will give you some idea of the cost factor involved and help explain industry's side of the question. In less than 3 mos. on this minor claim, the system required that we file 6 reports and if you don't think that's redundant and ridiculous and very expensive, then you and I are operating on totally different wave lengths.

By Renee Murray

Because we wish to serve you more quickly, we use this speed memo.

ADM-107