NOTICE OF POSSIBLE CLAIM
AGAINST THE SECOND INJURY FUND

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

(Type or Print)

(For AWCB Use Only)

Filing this notice meets the requirements of AS 23.30.205(f). The notice must be filed within 100 weeks of the date the employer or the employer's carrier obtained knowledge that the injury might possibly result in SIF compensable harm to the injured worker. Copies of this form and attachments must be served on all interested parties pursuant to 8 AAC 45.060.

1. Employee's Name (Last, First, Middle Initial)	**2.** Insurer Claim Number Date of Injury
3. Employee's Mailing Address	**4.** Employee's Social Security Number Date of Birth
5. Employer's Name	**6.** Insurer's Name
7. Employer's Mailing Address	**8.** Insurer's Mailing Address

9. Provide description of applicable qualifying pre-existing condition, as set out in AS 23.30.205(d).

10. Describe how the written records of the employer establish that the employer knew of the pre-existing condition prior to the subsequent occupational injury. (A copy of the written record must either be attached to this notice or to the Petition for reimbursement when filed)

11. Briefly describe how the pre-existing condition may combine with the occupational injury to create a compensable condition greater than the occupational injury alone. (Records documenting medical evidence of the combined effects must either be attached to this notice or to the Petition for reimbursement when filed.)

12. Provide date that the employer or insurer gained knowledge of the "combined effects" compensable condition described above. (Records documenting knowledge of the combined effects must either be attached to this notice or to the Petition for reimbursement when filed)

13. Name of Individual Submitting This Form	**14.** Signature of Individual Submitting Form	**15.** Date
16. Mailing Address		**17.** Telephone Number