Alaska Department of Labor and Workforce Development
Division of Workers' Compensation, Reemployment Benefits Section
3301 Eagle Street, Suite 301, Anchorage, Alaska 99503-4149
Telephone: 907.269.4985 – Fax: 907.334.2619

# EMPLOYER'S NOTICE TO OPT OUT OF STAY-AT-WORK BENEFITS FOR INJURIES ON OR AFTER JANUARY 1, 2025

| AWCB Case No. | | Date of Injury | |
|---|---|---|---|
| Employee's Name (Last, First, Middle Initial) | | Insurer/Adjusting Company | |
| Address | | Address | |
| City State Zip Code | Telephone | City State Zip Code | Telephone |
| Employee's Email Address | | | |

In accordance with 23.30.043(n), this serves as the employer's notification to opt out of the stay-at-work program. The employee shall continue in the reemployment benefits process as described in AS 23.30.041(c).

PROOF OF SERVICE: I certify that on ___/___/_____, I provided a true and correct copy of this election to opt out of Stay-at-Work benefits form on the following (Note: Employer's election form will be returned if it does not show service to all parties):

| | Mail | E-mail | Facsimile |
|---|---|---|---|
| a. The Employee | ☐ | ☐ | ☐ |
| b. The Program Coordinator | ☐ | ☐ | ☐ |
| c. The Rehabilitation Specialist | ☐ | ☐ | ☐ |
| d. Other | ☐ | ☐ | ☐ |

## FORM WILL BE RETURNED UNLESS SIGNED BELOW

| Name of Individual Filing this Form (Print or Type) | Signature | Date |
|---|---|---|
| Address | | |
| City | State | Zip Code |