EMPLOYER'S NOTICE
OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:
Your employer is insured by:

TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA
Insurer

One Tower Square
Street and Number

Hartford	CT	06183
City	State	Zip Code

For the period from _____ Through _____

The Travelers Insurance Companies
Adjusting Company

P.O. BOX 660456
Street and Number

Dallas	TX	75266	(800) 238-6225
City	State	Zip Code	Telephone

This insurance pays benefits for job-connected injuries, illnesses or death as provided by the Alaska Workers' Compensation Act

Rose International, Inc.
Employer

Human Resources
By

636-812-4000 Email: HR@roseint.com
Title

Witness

Witness

Immediately (not later than 30 days from injury or death date) give your employer and the Alaska Workers' Compensation Division written notice of a job-related injury, illness, or death. Get the “Report of Occupational Injury or Illness” form from your employer for this purpose

If you have questions about your rights or benefits under the Alaska Workers' Compensation Act, contact the insurer at the above address and the Alaska Workers' Compensation Division at the nearest office listed below:

ANCHORAGE
3301 Eagle Street
Suite 304
Anchorage AK 99503
(907) 269-4980

FAIRBANKS
675 7th Ave
Station K
Fairbanks AK 99701-4531
(907) 451-2889

JUNEAU
PO Box 115512
1111 W 8th St Rm 305
Juneau AK 99811-5512
(907) 465-2790

NOTICE TO EMPLOYER: AS 23.30.060 requires that you post this notice in three conspicuous places on the employer's premises.