

Fishermen's Fund

FISHERMAN'S REPORT OF INJURY/ILLNESS & CLAIM FORM

Toll Free:	1-888-520-2766
Telephone:	(907) 465-2766
Fax:	(907) 465-5345
E-mail:	fishfund@alaska.gov
	www.labor.state.ak.us/wc/ffund.htm

You must seek treatment within 60 days of injury, and file a claim within one year of first treatment. Complete each item below - benefits cannot be paid if you do not provide the requested information. Attach a copy of your license/permit card with this form.

1. Name (Last, First, Middle Initial)		2. Sex <input type="radio"/> M <input type="radio"/> F		3. Date of Birth		4. Social Security No.	
5. Street or PO Box Number				6. Home Telephone Number		7. Cell Phone Number	
8. City		State		Zip Code		9. E-mail Address optional	
10. Vessel Name		11. Owner of Vessel / Set Net Site		12. Vessel Owner's Telephone		13. Vessel Number	
14. Commercial Fishing License or Permit No.: _____ Date Purchased: _____ Must Attach Copy				15. Date and Time of Injury or Onset of Illness Date: _____ Time: _____ <input type="radio"/> AM <input type="radio"/> PM			
16. Geographic Location at Time of Injury (Chart Name or Description, Nearest Landmark, etc.) Be Specific				17. Ill/Injured While <input type="radio"/> Commercial Fishing <input type="radio"/> Working on Gear/Boat <input type="radio"/> Other:			
18. Resource Commercially Fished (ex. Salmon, Cod, Crab, etc.)				19. Gear Type (ex. Troll, Seine, Longline, Pot Gear, etc.)			
20. Is the vessel/site insured by a protection & indemnity (P&I) insurance policy? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know If yes, Insurance Company Name: _____							
Have you filed a claim against the vessel owner or the insurance company? <input type="radio"/> Yes <input type="radio"/> No							
21. At the time of your injury/illness, did you have medical coverage (including private health insurance, Indian health services, veteran's affairs, Medicare, Medicaid, etc.)? <input type="radio"/> Yes <input type="radio"/> No If yes, name of coverage provider: _____							
22. What is the exact nature of your injury/illness? Be Specific _____ _____ _____							
23. What caused the injury/illness? Be Specific _____ _____ _____							
24. What were you doing at the time of injury? Be Specific _____ _____ _____							
25. Was there a witness? <input type="radio"/> Yes <input type="radio"/> No If yes, witness name: _____ Witness Address: _____ Telephone Number: _____							
To all health care providers: You are authorized to provide the Alaska Commercial Fishermen's Fund information concerning any health care advice, testing, treatment, or supplies provided to me for the injury or illness described above in box 22. This information will be used to evaluate my entitlement to receive medical benefits from the Fund.							
Claimant Signature: _____				Date: _____			

Warning: It is a crime to provide false information for the purpose of defrauding the Alaska Commercial Fishermen's Fund, or any other person. Penalties include fines and/or imprisonment. In addition, the Fund may deny all benefits if false information materially related to this claim was provided by the claimant.