EMPLOYER'S NOTICE OF INSURANCE

TO THE EMPLOYEES OF THE UNDERSIGNED:

Your employer is insured by:

THE TRAVELERS INSURANCE COMPANIES

Insurer

P.O. BOX 660456

Street and Number DALLAS, TX 75266-0456

City _____ State _____ Zip Code _____

For the period from 01-01-25 Through 09-01-25

Adjusting Company

Street and Number

City _____ State _____ Zip Code _____ Telephone (800) 832-7839

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

Employer

By

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	FAIRBANKS	JUNEAU
3301 Eagle Street	675 7th Avenue	PO Box 115512
Suite 304	Station K	1111 W 8th St Rm 305
Anchorage AK 99503	Fairbanks AK 99701-4531	Juneau AK 99811-5512
(907) 269-4980	(907) 451-2889	(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.

Form 07-6120 (Rev 05/2012)