STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
333 WILLOUGHBY AVENUE, 9TH FLOOR
P.O. BOX 110805, JUNEAU, ALASKA 99811-0805

(907) 465-2515
FAX NUMBER: (907) 465-2816
Website: www.commerce.state.ak.us/insurance

Date Stamp Box

Date: _____

Control No.: _____

UNLICENSED ADJUSTER SINGLE LOSS OR CATASTROPHE FORM

Pursuant to AS 21.27.860(a), a nonresident independent adjuster not licensed by this state **who is licensed by and in good standing** with its home state may act as an adjuster and **adjust a single loss in this state during a calendar year,** or may act as an adjuster and adjust losses arising out of a catastrophe as declared by the director, **if, within 10 days after the start of the investigation or adjustment under this section** the nonresident adjuster has advised the director in writing of the adjustment.

- Registration must be filed within 10 days of the adjustment or investigation
- Must be licensed as independent adjuster in home state
- If catastrophic loss, the event must be declared by the Director of Insurance
- Adjuster may be sued pursuant to AS 21.27.860(b)
- Must comply with Unfair Claims Trades Practices Regulation
- An original Certificate of License Status, current within 90 days of issuance must be filed reflecting licensure as an independent adjuster

1. Last Name JR./SR. etc.	2. First Name	3. Middle Name	4. Date of Birth month_____ day _____ year _____
5. Social Security Number	6. Home Phone Number	7. Home E-mail Address	8. Gender (circle one) Male Female
9. Residence/Home Address (Physical Street)	10. P.O. Box	11. City	12. State / 13. Zip or Foreign Country
14. Are you a Citizen of the United States (check one) Yes ☐ No ☐ (If No, of which country are you a citizen?) (If No and you are a resident, you must supply work authorization.) Country: _____	15. Firm Name		
16. Firm Address (Physical Street)	17. City	18. State	19. Zip or Foreign Country
20. Firm Phone Number	21. Firm Fax Number	22. Firm E-mail Address	23. Firm Website Address
24. Applicant's Mailing Address	25. City	26. State	27. Zip or Foreign Country
28. Name of Insurer(s) you Represent	29. Effective Date of Contract with Insurer Represented		
30. Name of Insured/Claimant	31. Start Date of Adjustment/Investigation	32. Date of Loss	33. Policy Number

34. By signature below, I certify that, under penalty of perjury:

A. All of the information submitted in this application and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me to civil or criminal penalties.

B. I grant permission to the Director of Insurance for which this application is made to verify any information supplied with any federal, state or local government agency, current or former employer or insurance company.

C. I authorize the State of Alaska to give any information they may have concerning me to any federal, state or municipal agency, or any other organization and I release the State of Alaska and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information.

Must be signed and dated by applicant.

_____
Signature of Applicant

_____
Type or Printed Name

_____
Month/Day/Year