Oregon
Kate Brown, Governor

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BULLETIN NO. 102 (Revised)
Nov. 7, 2022

TO: Workers' compensation insurers and self-insured employers

SUBJECT: Reimbursement from the Retroactive Program

EFFECTIVE: Jan. 1, 2023

This bulletin provides the format for requesting reimbursement from the Retroactive Program. The division is revising this bulletin and Form 3285, "Request for Reimbursement from the Retroactive Program," to include the following updates:

- **Update the term "invalid" child to "incapacitated" child (House Bill 4068, effective Jan. 1, 2023)**
- **Update the term "widow" to "surviving spouse"**
- **Update the division's contact information**

This bulletin replaces Bulletin No. 102 dated Sept. 12, 2017.

The Workers' Compensation Division will reimburse insurers for program benefits paid by insurers in accordance with Oregon Revised Statute 656.506 and Oregon Administrative Rule 436-075. Insurers must submit separate requests for each company within an insurer group. Reimbursement requests must be mailed or delivered to the division within 30 days after the end of each quarter to be processed in that quarterly disbursement. Late requests will be held over and processed with the next quarterly disbursement.

Requests for reimbursement must include the data elements listed below, for each type of benefit paid. The insurer may use the self-calculating form (Form 3285) available on the Workers' Compensation Division's website: http://wcd.oregon.gov/forms/pages/forms.aspx, or its own equivalent form. An example of a completed Form 3285 is also attached.

Fatal

A. Injured worker name
B. Insurer claim number
C. Injured worker date of birth
D Date of injury
E. Marital and dependency status
   Note: Fill in this field using alpha-number*
   (Example: W-0, R-2, etc.)
   Orphan: O
   Remarried: R
   Surviving spouse: W
F. Spouse date of birth
G. Children dates of birth
H. Incapacitated child
I. Statutory monthly payment
J. Total months requested this quarter
K. Amount of retroactive benefits paid

Permanent Total Disability

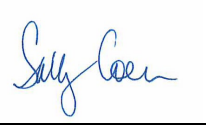
A. Injured worker name
B. Insurer claim number
C. Injured worker date of birth
D. Date of injury
E. Weekly wage at time of injury
F. Marital and dependency status
   Note: Fill in this field using alpha-number*
   (Example: S-0, M-2, etc.)
   Married: M
   Single: S
G. Spouse date of birth
H. Children dates of birth
I. Incapacitated child
J. Statutory monthly payment
K. Amount of Social Security offset, if applicable
L. Total months requested this quarter
M. Amount of retroactive benefits paid

*The number in S-0, M-2, etc. is the number of dependents. If there are more than five dependents, enter "5."

Temporary Total Disability

A. Injured worker name
B. Insurer claim number
C. Date of injury
D. Weekly wage at time of injury
E. Scheduled days off
F. Statutory weekly payment
G. Total weeks paid this quarter
H. Paid from date
I. Paid through date
J. Amount of retroactive benefits paid

If you have questions about this bulletin or Form 3285, contact the Reimbursements Team by email, WCD.SIRR-Reimbursements@DCBS.oregon.gov, or by phone, 503-947-7189.



Sally Coen, Administrator
Workers' Compensation Division

Distribution: WCD-LY, electronic mailing lists

Attachments: Form 3285, "Request for Reimbursement from the Retroactive Reserve" (Rev. 1/23)
Form 3285, Example