WCD Workers' Compensation Division
Department of Consumer and Business Services

Insurer's notification of business in Oregon

Insurer information

Insurer's name: _____ FEIN: _____

NAIC no: _____ NCCI no: _____ COA no: _____

Group name: _____ NAIC group no.: _____

Insurer's address and contacts for Oregon Workers' Compensation

Headquarters address:

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP+4: _____

General delivery email address for company: _____

Headquarters primary company contact:

Name: _____ Title: _____ Phone: _____

Email address: _____ Fax: _____

Insurer's Oregon address (if applicable):

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP+4: _____

Oregon office primary contact for workers' compensation (if applicable):

Name: _____ Title: _____ Phone: _____

Email address: _____ Fax: _____

Claims information contact:

Claims information phone number to be published on WCD's coverage look-up website: _____

NOTE: *Insurers must provide a phone number that will provide information on where claims are processed in Oregon. The number will be displayed on the Workers' Compensation Division's (WCD) website. OAR 436-050-0110(2)(b)*

Claims processing location mailing address ***for insurers with a single Oregon processing location***:

Street or P.O. Box: _____

City: _____ State: _____ ZIP+4: _____

Web-based claims location look-up (optional) – Web address: _____

440-1352 (3/24/DCBS/WCD/WEB)

1352

Payment and collections contact:

NOTE: *Insurers must provide a contact for payment of penalties and resolution of collection issues resulting from orders issued by the director. OAR 436-050-0110(2)(b)*

Name: _____ Title: _____ Phone: _____

Email address: _____ Fax: _____

Street or P.O. Box: _____

City: _____ State: _____ ZIP+4: _____

Policy and proof of coverage contact:

NOTE: *Insurers must provide a designated person or position within the company who can respond to workers' compensation policy and proof-of-coverage filing inquiries. OAR 436-050-0110(2)(b)*

Name: _____ Title: _____ Phone: _____

Email address: _____ Fax: _____

Street or P.O. Box: _____

City: _____ State: _____ ZIP+4: _____

Insurer's service company in Oregon (if any)

Service company name: _____

Physical Oregon address: _____

Mailing address: _____

City: _____ State: _____ ZIP+4: _____

Service company contact in Oregon:

Name: _____ Title: _____ Phone: _____

Email address: _____ Fax: _____

NOTE: If an insurer elects to use a service company, a copy of the agreement between the insurer and the service company must be submitted and approved before using the service company in Oregon. OAR 436-050-0110(4)(b)

IMPORTANT: If the insurer's place of business, or that of its service company, is changed, the insurer must notify the Workers' Compensation Division of the new location and mailing address of the place of business **at least 30 days** before the effective date of the change. OAR 436-050-0110(3)

If you have questions, contact the insurer registration specialist, Workers' Compensation Division, **503-947-7705.**

Mail this form to:
Workers' Compensation Division
Attn: Insurer Registration
P.O. Box 14480
Salem, OR 97309-0405

Or fax it to: 503-947-7725

Or email it to:
insurerregistration.wcd@dcbs.oregon.gov

Insurer representative completing form:

Name: _____ Title: _____ Date: _____

Phone: _____ Fax: _____ Email: _____

For department use

WCD no.: _____ Date processed: _____ Rates eff: _____

Date rec'd: _____ Initials: _____ COA w/WC: _____