|  |  |  |
| --- | --- | --- |
| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg | Supplemental Disability Benefits**Quarterly Reimbursement Request** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  **Self-insured employer** **[ ]  Insurance company** | Quarter: |  | Year |  |
| **To:** | Department of Consumer and Business Services**Workers’ Compensation Division, Performance Section****Self-Insurance, Registration, and Reimbursements Unit** **350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405** | **I certify that payments reported have been made in the amounts indicated and have not been previously requested. Reimbursement is requested in the amount of:** | **$0.00** |
|  |  |  | From: | Insurance company or self-insured employer **(and service company if applicable)** name and address: |  |
| Signed: | **X** |  | Date:  |       |   |  |  |
|  |  |  |  |  |  |  |  |
| Name and title: |  | (Print or type) |  |  |
| Phone: |  | (Print or type) |  | City State ZIP |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Worker’s name, WCD file number,date of injury, SSN, andinsurer claim number | Claim status | Employer legal names | Employer’s policy number\* | Weekly wage | Supplemental disability periods | Supple-mental disability payments | Quarter/year payment made | WCD useonly |
|  | Nondis. orDisabling |  |  |  |  |  |  |  |
|  | N | D |  |  |  |  |  |  |  |
|  |  |  |  |  |  | From: | Through: |  |  |  |
| Worker:WCD#: Date of injury: SSN:Ins. #:  | **[ ]**  | **[ ]**  | Primary employer:  |  | Weekly wage: |  |  | **$**  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Scheduled days off:      |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Additional employer #1:  |  | Pre-injury weekly wage: |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Additional employer #2  |  | Pre-injury weekly wage: |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Worker:WCD#: Date of injury: SSN:Ins. #:  | **[ ]**  | **[ ]**  | Primary employer:  |  | Weekly wage: |  |  | **$**  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Scheduled days off:      |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Additional employer #1:  |  | Pre-injury weekly wage: |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  | Additional employer #2  |  | Pre-injury weekly wage: |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **\*Employer policy number:** Call the Employer Compliance Unit at 503-947-7814; fax requests to 503-947-7718; email requests to wcd.employerinfo@dcbs.oregon.gov; look up information on WCD’s website: **http://www4.cbs.state.or.us/ex/wcd/cov/.** 440-3504 (8/25/DCBS/WCD/WEB) |