|  |  |  |
| --- | --- | --- |
| 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, and  insurer 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 use  only |
|  | Nondis. or  Disabling | |  |  |  |  | |  |  |  |
|  | 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) | | | | | | | | | | |