WCD Workers' Compensation Division
Department of Consumer and Business Services

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: $ _____

Signed: **X** _____ Date: _____

Name and title: _____ (Print or type)

Phone: _____ (Print or type)

From: Insurance company or self-insured employer **(and service company if applicable)** name and address: _____

City State ZIP

Worker's name, WCD file number, date of injury, SSN, and insurer claim number	Claim status: Nondis. or Disabling N	Claim status: Nondis. or Disabling D	Employer legal names	Employer's policy number*	Weekly wage	Supplemental disability periods From:	Supplemental disability periods Through:	Supplemental disability payments	Quarter/ year payment made	WCD use only
Worker: WCD#: Date of injury: SSN: Ins. #:	☐	☐	Primary employer: Scheduled days off: Additional employer #1: Additional employer #2		Weekly wage: Pre-injury weekly wage: Pre-injury weekly wage:			$		
Worker: WCD#: Date of injury: SSN: Ins. #:	☐	☐	Primary employer: Scheduled days off: Additional employer #1: Additional employer #2		Weekly wage: Pre-injury weekly wage: 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/.**