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| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg | | | **SUPPLEMENTAL DISABILITY ELECTION NOTIFICATION** | | | | | | | | | |
|  | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | elects to have the assigned processing | |
| Insurer / self-insured employer name | | | | | | | | | | |  | |
| agent administer and pay supplemental temporary disability benefits. | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | |  |  | |  | | | |
| Insurer representative signature | | | | | | |  | Date | |
| Insurer representative name (printed): | | | | | |  | | | | | |  |
| Title: |  | | | | | | | | | | |
| Phone: |  | | | |  | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| If you have questions about this form, call the Self-Insurance, Registration, and Reimbursements Unit at503-947-7189. | | | | | | | | | | | | |
|  | | |  | | | | | | | | | |
| Mail or deliver to: | | Workers’ Compensation Division Self-Insurance, Registration, and Reimbursements Unit  350 Winter St. NE  P.O. Box 14480  Salem, OR 97309-0405 | | | | | | |  | | | |
|  | | |  | | | | | | | | | |
| Or fax to 503-947-7725 | | |  | | | | | | | | | |
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| 440-3530 (8/25/DCBS/WCD/WEB) | | | |  | | | | | | | | |