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| http://inside.cbs.state.or.us/docs/branding/logos/wcd/en/JPEG/WCD-logo-black.jpg | **SUPPLEMENTAL DISABILITY ELECTION NOTIFICATION** |
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|  |
|       | 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 at 503-947-7189. |
|  |  |
| Mail or deliver to: | Workers’ Compensation DivisionSelf-Insurance, Registration, and Reimbursements Unit350 Winter St. NEP.O. Box 14480Salem, OR 97309-0405 |  |
|  |  |
| Or fax to 503-947-7725 |  |
|  |
| 440-3530 (8/25/DCBS/WCD/WEB) |  |