Department of Consumer and Business Services

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 at 503-947-7189.

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