Workers' Compensation Division
Department of Consumer and Business Services

# Insurer Contact Update

***IMPORTANT:*** The insurer must notify the Oregon Workers' Compensation Division **at least 30 days** before the effective date of a change in contact information. See OAR 436-050-0110 (insurers) and OAR 436-050-0210 (self-insured employers) for more details on contact requirements.
***NOTE:*** Submit contact updates per insurer, not per group.

## Insurer Information

Insurer's full name: _____ FEIN: _____

Group name: _____ NAIC: _____

## Required Contact Information

### Headquarters (HQ):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Payments and Collection (PAC):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Coverage Processing (CVGC):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Claim Referral Information (CRI):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

## Optional Contact Information

### Claims Processing (CLM):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Premium Assessment (PADS):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Quarterly Claim Processing Performance (QCPP):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Electronic Data Interchange – proof of coverage filing (EDIP):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

### Electronic Data Interchange – medical billing (EDIM):

Contact person: _____ Phone: _____

Email: _____ Fax: _____

Street address: _____

Mailing address: _____

City: _____ State: _____ ZIP: _____

***If you have questions, contact insurer registration, Workers' Compensation Division, at 503-947-7603 or 503-947-7705.***

**Mail this form to:** OR Workers' Compensation Division
Attn: Insurer Registration
P.O. Box 14480
Salem, OR 97309-0405

**Or fax it to:** 503-947-7725

**Or email it to:** insurerregistration.wcd@oregon.gov

**Insurer representative completing form:**

Name: _____ Title: _____ Date: _____

Phone: _____ Fax: _____ Email: _____

| For department use | |
|---|---|
| WCD number: _____ | Date received: _____ |
| Initials: _____ | Date processed: _____ |