



Oregon

Kate Brown, Governor

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Sept. 29, 2021

Proposed Changes to Workers' Compensation Rules

Caption: Claims processing location; claims recordkeeping; casual labor threshold

The Workers' Compensation Division proposes to amend:

[OAR 436-050, "Employer/Insurer Coverage Responsibility"](#) and
[OAR 436-060, "Claims Administration."](#)

When is the hearing? Oct. 18, 2021, 10:30 a.m.

Where is the hearing? Virtual hearing – Join ZoomGov Meeting:

<https://www.zoomgov.com/j/1618372629?pwd=UVhUbEVydE44TWFIYkxMWVdyMGF3dz09>

Meeting ID: 161 837 2629 | Passcode: 379967

Dial-in: 1-833-568-8864 US Toll-free | Meeting ID: 161 837 2629

How can I make a comment? Connect to the hearing and speak, send written comments, or do both. Send written comments to:
Email – WCD.Policy@dcbs.oregon.gov
Attention: rules coordinator
Workers' Compensation Division
350 Winter Street NE (for courier or in-person delivery)
PO Box 14480, Salem, OR 97309-0405
Fax – 503-947-7514

The closing date for written comments is Oct. 25, 2021.

Questions? Contact Fred Bruyns, 503-947-7717.

Proposed rules and public testimony are available on the Workers' Compensation Division's website:
<http://wcd.oregon.gov/laws/Pages/proposed-rules.aspx>. Or, call 503-947-7717 to get paper copies.

Auxiliary aids for persons with disabilities are available upon advance request.

Summary of proposed changes to OAR 436-050, “Employer/Insurer Coverage Responsibility”:

- Amended rule 0005 revises the definition of claims processing location, replacing a requirement to “keep” records with a requirement to “make records available.”
- Amended rule 0040 defines “sole proprietorship,” as the term is used in section (1) of the rule.
- Amended rule 0045:
 - Defines casual labor and explains that the casual labor threshold will be published by a department bulletin; and
 - Has minor wording changes to enhance clarity.
- Amended rule 0110:
 - Replaces a requirement to maintain records at the claims processing location with a requirement to make claims available from the location;
 - Establishes criteria for claims processing from remote locations, including locations outside the State of Oregon;
 - Creates a process for suspension and restoration of an insurer’s authority to process claims remotely from its designated claims processing locations; and
 - Removes a provision about assessment of civil penalties that is adopted under OAR 436-050-0500.
- Amended rule 0120:
 - Replaces a requirement to “keep” records with a requirement to “maintain” records at an Oregon claims processing location, and requires the insurer to “provide access” to those records to the director upon request; and
 - Specifies options for making physical and electronic records available, including archived records; and requires insurers to make records accessible to the director on request, either by making the records available at an Oregon claims processing location or by providing electronic access.
- Amended rule 0165 provides that Form 1810, "Surety Bond Rider" must be used for all changes to the name of the Principal.
- Amended rule 0180 provides a more specific citation to a document used in determining the claims processing administrative costs, adding “(Workers’ Compensation)” to “Schedule P, Part ID (Workers’ Compensation) of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner”
- Amended rule 0210:
 - Replaces a requirement to maintain records at the claims processing location with a requirement to make claims available from the location;
 - Establishes criteria for claims processing from remote locations, including locations outside the State of Oregon;
 - Creates a process for suspension and restoration of a self-insured employer’s authority to process claims remotely from its designated claims processing locations; and
 - Removes a provision about assessment of civil penalties that is adopted under OAR 436-050-0500.
- Amended rule 0220:
 - Replaces a requirement to “keep” records with a requirement to “maintain” records at an Oregon claims processing location, and requires self-insured employers to “provide access” to those records to the director upon request; and
 - Specifies options for making physical and electronic records available, including archived records, and requires self-insured employers to make records accessible to the director on request, either by making the records available at an Oregon claims processing location or by providing electronic access.

Notice of proposed rulemaking hearing

- Amended rule 0230 clarifies that a self-insured employer requires the director's permission to operate an out-of-state claims processing location, rather than to process claims remotely from an Oregon location.
- Amended rule 0300 clarifies that in years when the director applies an IBNR factor greater than zero when determining the amount of a self-insured employer group's security deposit, the group is not required to maintain a common claims fund.
- Adopted rule 0500 describes the director's authority to assess a civil penalty under ORS 656.745(2) against an employer or insurer that violates ORS chapter 656, OAR 436-050, or an order of the director.

Summary of proposed changes to OAR 436-060, "Claims Administration":

- Amended rule 0005 defines "date stamp."
- Amended rule 0015 requires the insurer, self-insured employer, or service company to send the worker contact information that will:
 - Reasonably lead the worker to an Oregon certified claims examiner during normal business hours; and
 - Reasonably ensure that inquiries from the worker are responded to within 48 hours, not including weekends or legal holidays.
- Amended rule 0017:
 - Amends the definition of "documents" to better align with the Workers' Compensation Board's rules on disclosure of documents under OAR 438-007-0015.
 - Specifies that an insurer or service company must date stamp each claim document in its possession on the date received;
 - Explains that the insurer may provide electronic or paper copies of documents requested under this rule, unless the worker's attorney, worker's beneficiary, or beneficiary's attorney specifically requests paper copies; and
 - Requires that if a requested claim record is lost or destroyed, the insurer must notify the director, in addition to the requester.
- Amended rule 0035 has a revised citation to a renumbered definition in rule 0005.
- Amended rule 0180 has a revised citation to a renumbered section in rule 0017.

The agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing the negative economic impact of the rule on business.

Need for the Rule(s): Changes are needed primarily to implement passed legislation, enrolled HB 2039 (2021 Oregon Laws chapter 21) and enrolled HB 3188 (2021 Oregon Laws chapter 257). Additional changes are needed to provide clear direction regarding maintenance and release of claim records, to enhance clarity, and to provide that an existing form must be used to report a name change of a Principal on a surety bond.

Documents Relied Upon, and where they are available: Rulemaking advisory committee meeting records; Enrolled House Bill 2039 (2021 Oregon Laws chapter 21); Enrolled House Bill 3188 (2021 Oregon Laws chapter 257). These documents are available for public inspection upon request to the Workers' Compensation Division, 350 Winter Street NE, Salem, Oregon 97301-3879. Please contact Fred Bruyns, rules coordinator, 503-947-7717, WCD.Policy@oregon.gov.

Fiscal and Economic Impact: The agency does not anticipate that any of the proposed rule changes, if adopted, will result in significant fiscal or economic impacts to the agency.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):

- a. The agency estimates that proposed rule changes will not increase or decrease costs to state agencies for compliance with the rule.
- b. The agency estimates that proposed rule changes will not increase or decrease costs to units of local government for compliance with the rule, with the exception of some government entities that are self-insured – see 1.c. (below).
- c. The agency estimates that proposed rule changes will generally not increase or decrease costs to the public for compliance with the rule. However, the requirement that the insurer, self-insured employer, or service company send contact information to the worker that will reasonably lead the worker to an Oregon certified claims examiner during normal business hours, and reasonably ensure that inquiries from the worker are responded to within 48 hours, not including weekends or legal holidays, may add a small cost for companies that do not already meet these requirements. The agency does not have data it can use to project the actual costs, but invites testimony from affected companies.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:

Insurers and self-insured employers are generally not small businesses, but as many as ten service companies are small businesses and are subject to these rules.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:

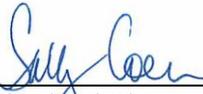
The requirement to send contact information to the worker as described in 1.c. (above) may add a small cost for companies that do not already meet these requirements.

c. Equipment, supplies, labor and increased administration required for compliance:

The agency does not project additional costs for equipment, supplies, labor, or increased administration required for compliance with proposed rule changes.

How were small businesses involved in the development of this rule? The agency sent invitations to more than 4,000 stakeholders, including representatives of small businesses, to participate on a rulemaking advisory committee and to submit agenda topics. The advisory committee included members representing the interests of small businesses.

Administrative Rule Advisory Committee consulted?: Yes **If not, why?**


Authorized Signer

Sally Coen
Printed name

Sept. 29, 2021
Date



Employer/Insurer Coverage Responsibility

Oregon Administrative Rules

Chapter 436, Division 050

Proposed Effective Jan. 1, 2022

TABLE OF CONTENTS

Rule	Page
436-050-0005 Definitions.....	1
COVERAGE	3
436-050-0040 Responsibility for Providing Coverage When a Contract Is Awarded	3
436-050-0045 Nonsubject Workers.....	3
INSURERS	4
436-050-0110 Notice of Insurer's Place of Business in State; Records Insurer Must Maintain	4
436-050-0120 Records Insurers Must Maintain; Removal and Disposition	10
SELF-INSURED EMPLOYERS	12
436-050-0165 Security Deposit Requirements.....	12
436-050-0180 Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit.....	16
436-050-0210 Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must Maintain	19
436-050-0220 Records Self-Insured Employer Must Maintain; Period to be Retained, Removal and Disposition	25
436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation	26
436-050-0300 Self-Insured Employer Group, Common Claims Fund	28
436-050-0500 Assessment of Civil Penalties.....	28

HISTORY LINES: These rules include only the most recent "History" lines. The history line shows when the rule was last revised and its effective date. To obtain a comprehensive history for OAR chapter 436, please call the Workers' Compensation Division, 503-947-7627, or visit the division's website: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

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**OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 050**

NOTE: Revisions are marked as follows: [new text](#) | ~~deleted text~~.

436-050-0005 Definitions

Unless a term is defined elsewhere in these rules, the definitions of ORS chapter 656 are incorporated by reference and made a part of these rules. For the purpose of these rules, unless the context requires otherwise:

- (1) **“Assigned claims agent”** means an entity selected by the director to process the claims of a non-complying employer under ORS 656.054.
- (2) **“Audited financial statement”** means a financial statement audited by an outside accounting firm.
- (3) **“Board”** means the Workers’ Compensation Board and includes its Hearings Division.
- (4) **“Cancel”** or **“cancellation,”** in relation to an insurance policy, means ending the policy at a date before its expiration date.
- (5) **“Claims processing location”** means a place of business maintained or operated by an insurer, self-insured employer, self-insured employer group, or service company to process claims and [keep-make](#) records [available as required by ORS 731.475 and 656.455](#). “Claims processing location” does not include a post office box, commercial mail receiving agency, virtual office, or the place of residence of an employee of the insurer, self-insured employer, self-insured employer group, or service company.
- (6) **“Days”** means calendar days unless otherwise specified.
- (7) **“Default”** means failure of an employer, insurer, or self-insured employer to pay the moneys due to the director under ORS 656.506, 656.612, and 656.614 at such intervals as the director directs.
- (8) **“Director”** means the director of the Department of Consumer and Business Services or the director’s designee.
- (9) **“Division”** means the Workers’ Compensation Division of the Department of Consumer and Business Services.
- (10) **“Governmental subdivision”** means a city, county, special district as defined in ORS 198.010, intergovernmental agency created under ORS 225.050, school district as defined in ORS 255.005, public housing authority created under ORS chapter 456, or regional council of governments created under ORS chapter 190.
- (11) **“Insurer”** means the State Accident Insurance Fund Corporation or an insurer authorized under ORS chapter 731 to transact workers’ compensation insurance in Oregon.
- (12) **“Nonrenewal”** means the insurer’s decision not to renew a policy at its expiration date.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

(13) **“Person”** means an individual, partnership, corporation, joint venture, limited liability company, association, government agency, sole proprietorship, or other business entity allowed to do business in the State of Oregon.

(14) **“Premium”** means the monetary consideration for an insurance policy.

(15) **“Premium assessments”** means moneys due the director under ORS 656.612 and 656.614.

(16) **“Principal”** means the entity whose liability is secured by a surety bond.

(17) **“Process claims”** means the determination of compensability and management of workers' compensation claims by an Oregon certified claims examiner.

(18) **“Proof of coverage”** has the meaning provided under OAR 436-162-0005.

(19) **“Reinstatement”** means the continuation or reestablishing of workers' compensation insurance coverage under a workers' compensation insurance policy that was previously canceled.

(20) **“Renewal”** or **“renew”** means the issuance of a policy succeeding a previously issued policy or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date.

(21) **“Self-insured employer”** means an employer certified under ORS 656.430 as having met the qualifications of a self-insured employer under ORS 656.407.

(22) **“Self-insured employer group”** means five or more employers certified under ORS 656.430 as having met the qualifications of a self-insured employer under ORS 656.407.

(23) **“Service company”** means the contracted agent for an insurer, self-insured employer, or self-insured employer group authorized to process claims and make payment of compensation on behalf of the insurer, self-insured employer, or self-insured employer group.

(24) **“State”** means the state of Oregon.

(25) **“Written”** means information communicated in writing, and includes electronic records.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.726(4)

Hist: Amended 11/14/18 as WCD Admin. Order 18-061, eff. 1/1/19

Amended 12/17/19 as Admin. Order 19-057, eff. 1/1/20

Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

See also: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

COVERAGE

436-050-0040 **Responsibility for Providing Coverage When a Contract Is Awarded**

(1) If a person, including a person that is a sole proprietorship, that is responsible to provide coverage for an individual performing labor under ORS 656.029, fails to comply with ORS 656.017, that person is considered a noncomplying employer. As used in this section, "sole proprietorship" means a business entity or individual who performs labor without the assistance of others.

(2) As used in ORS 656.029, "the performance of labor where such labor is a normal and customary part or process of the person's trade or business" includes the day-to-day activities or operations which are necessary to successfully carry out the business or trade.

(3) A person contracting to pay remuneration for professional real estate activity as defined in ORS chapter 696, to a qualified real estate broker as defined in ORS 316.209, is not an employer of the qualified real estate broker, and is not required to provide coverage under ORS 656.017.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.029 and 656.037

Hist: Amended 11/28/16 as WCD Admin. Order 16-054, eff. 1/1/17

Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0045 **Nonsubject Workers**

For the purposes of clarifying terms used in ORS 656.027:

~~(1) "Private employment contract" means a contract under which a worker is directly employed by the owner of the private home. As used in this section, "owner of the private home" means:~~

~~(a) Any person who occupies and owns, leases, or rents the private home;~~

~~(b) Any person related by blood, marriage, or Oregon registered domestic partnership to a person described under subsection (a); or~~

~~(c) Any person who, by direction of a person described under subsection (a), or by order of a court, has become responsible for managing the household affairs of that person.~~

(1) "Casual labor" means any employment where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost lower than the dollar amount published in **Bulletin ### {to be assigned}**.

(2) "Home health worker" does not include a worker employed by a home health agency, as defined in ORS 443.014, or in-home care agency, as defined in OAR 333-536-0005.

~~(3)~~ A "Person performing foster parent or adult foster care duties" means:

(a) A person performing foster parent duties, including, but not limited to:

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

- (A) Any person certified as a foster parent by the Oregon Department of Human Services under ORS chapter 418; or
- (B) Any person employed by a certified foster parent in the operation of a foster home as defined in ORS chapter 418; or
- (b) A person performing adult foster care duties, including, but not limited to:
- (A) Any person operating an adult foster home licensed under ORS 443.705 to 443.825; or
- (B) Any person employed by the operator to perform services that assist the residents of the adult foster home.
- (c) An ~~an~~ **“adult foster home”**; as used in subsection (b), means any family home or facility, licensed under ORS 443.705 to 443.825, in which room, board, and 24-hour care services are provided, for compensation, to five or fewer adults who are not related to the operator by blood or marriage.

(4) “Private employment contract” means a contract under which a worker is directly employed by the owner of the private home. As used in this section, “owner of the private home” means:

- (a) Any person who occupies and owns, leases, or rents the private home;**
- (b) Any person related by blood, marriage, or Oregon registered domestic partnership to a person described under subsection (a); or**
- (c) Any person who, by direction of a person described under subsection (a), or by order of a court, has become responsible for managing the household affairs of that person.**

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.027

Hist: Amended 12/17/19 as Admin. Order 19-057, eff. 1/1/20

Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

INSURERS

436-050-0110 Notice of Insurer’s Place of Business in State; ~~Coverage~~ Records Insurer Must ~~Keep in Oregon~~ **Maintain**

(1) Oregon claims processing location required.

Except as described in section (4) of this rule, every insurer that is authorized to issue workers’ compensation policies to Oregon subject employers must establish and maintain at least one designated Oregon claims processing location as required by ORS 731.475, subject to the following:

- (a) The insurer must conduct all claims processing activities necessary to meet the requirements of ORS chapter 656 and OAR chapter 436 from its designated claims processing locations, including, but not limited to:

- (A) Processing claims;

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

- (B) ~~Maintaining~~ Making available all records required under OAR 436-050-0120; and
- (C) Responding to specific claims processing inquiries;
- (b) At the director's request, the insurer must:
- (A) Make claims processing locations ~~must be made~~-accessible during regular business hours or other reasonable times to accommodate periodic audits and examination of records; or
- (B) Provide the director electronic access to the records to be audited or examined.~~and~~
- (c) The insurer may ~~not process or maintain records of~~ claims subject to ORS chapter 656 remotely. As used in this subsection, to "process claims remotely" means to process claims outside of an insurer's Oregon claims processing location, including at the place of residence of an employee of the insurer, as directed from the Oregon claims processing location. at any location outside of the state, subject to the following:
- (A) The insurer may not process claims at places of business outside of Oregon that are maintained or operated by the insurer or a service company, except as follows:
- (Ai) The insurer may receive claim reports at locations outside of ~~the state~~Oregon if claims are forwarded to an Oregon claims processing location for processing; and
- (Bii) Payments may be made from outside of ~~the state~~Oregon as directed from the Oregon claims processing location.
- (B) The director may suspend an insurer's authority to process claims remotely, subject to the following:
- (i) The director may suspend an insurer's authority to process claims remotely when:
- (I) The director finds the insurer has repeatedly violated ORS chapter 656 or OAR chapter 436; and
- (II) The director has reason to believe that the violations are related to the insurer's practice of processing claims remotely.
- (ii) The director will not suspend an insurer's authority to process claims remotely until the insurer has been given notice and the opportunity to be heard through a show-cause hearing with the director. During the show-cause hearing, the insurer will be provided an opportunity to:
- (I) Present evidence regarding the proposed order to suspend the insurer's authority to process claims remotely; and
- (II) Give reason why the insurer should be permitted to continue processing claims remotely.
- (iii) If the director suspends an insurer's authority to process claims remotely, the insurer may not process claims remotely for a specified period of time, up to two

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

years.

(iv) The insurer may request the director restore the insurer's authority to process claims remotely by submitting a plan demonstrating its ability and commitment to comply with ORS chapter 656 and OAR chapter 436.

(v) The insurer may request a hearing on an order of suspension issued under this rule under OAR 436-050-0008(4).

(2) Notice of insurer's business in Oregon.

The insurer must give the director notice of its business in Oregon, subject to the following:

(a) The notice must be filed with the director not more than 30 days after the insurer is authorized and starts writing workers' compensation insurance policies for Oregon subject employers;

(b) The notice must include:

(A) The insurer's:

(i) Legal name;

(ii) Federal Employer Identification Number;

(iii) Identification numbers assigned by the National Association of Insurance Commissioners and the National Council on Compensation Insurance; and

(iv) Certificate of Authority number issued by the director;

(B) The insurer's principal place of business, including its street and mailing addresses, telephone number, and a general email address that is monitored on a regular basis, where the director can direct general inquiries;

(C) A primary contact at the insurer's principal place of business, including the contact's name, title, phone number, fax number, and email address;

(D) If the insurer maintains an Oregon claims processing location:

(i) The street and mailing addresses, and telephone number of the claims processing location; and

(ii) The name, title, phone number, fax number, and email address of a primary contact for the claims processing location;

(E) Contact information for:

(i) A designated person or position within the company who will assure payment of penalties and resolution of collections issues; and

(ii) A designated person or position within the company who can respond to workers' compensation policy and proof of coverage filing inquiries;

(F) If the insurer uses more than one Oregon claims processing location, or locations operated by service companies as described in section (4) of this rule:

(i) The name of each service company, if applicable;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

- (ii) The street and mailing addresses of each claims processing location; and
- (iii) The name, title, phone number, and email address of a contact person at each claims processing location; and

(G) Any other information requested by the director;

(c) The information provided under this section must reasonably lead an inquirer to an Oregon certified claims examiner who can respond to inquiries regarding workers' compensation policies, claim filing, claims processing, and claims processing location information within 48 hours, not including weekends or legal holidays; and

(d) The insurer may use [Form 1352](#), "Insurer's notification of business in Oregon," to satisfy the requirement of this section.

(3) Changes in information.

An insurer must notify the director of a change in any of the information required under section (2) of this rule, subject to the following:

(a) The notice must be filed at least 30 days before the effective date of the change; and

(b) The insurer may use [Form 5188](#), "Insurer Contact Update," to satisfy the requirements of this section.

(4) Service companies.

In lieu of, or in addition to, establishing and maintaining its own claims processing locations in Oregon, the insurer may use Oregon claims processing locations operated by service companies to satisfy the requirements of section (1) of this rule. If an insurer elects to use claims processing locations operated by one or more service companies with respect to all or any portion of its business:

(a) Each service company must be incorporated in or authorized to do business in Oregon;

(b) The insurer must provide the director with a copy of the service agreement between the insurer and each service company for approval. The director must approve the service agreement before the service company begins processing the insurer's Oregon claims, regardless of the agreement's effective date. To be approved, the service agreement must:

(A) Be an agreement for claims processing services between the underwriting insurer and a service company, and must not be between any other third parties;

(B) Identify the insurer by company name, or if the agreement includes multiple insurers related by ownership, by the name of the group if it includes all affiliates;

(C) Identify the service company by name;

(D) Describe the claims processing services to be provided;

(E) Identify the effective date of the agreement;

(F) Identify the termination date of the agreement, if any;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

- (G) Grant the service company a power of attorney to act for the insurer in workers' compensation coverage and claims proceedings under ORS chapter 656, subject to the following:
- (i) The power of attorney must be effective the same date of the service agreement;
 - (ii) The power of attorney must not be revocable before all claims processing services provided under the service agreement have concluded;
 - (iii) The power of attorney must be applicable to all claims processed under the agreement, and may not have unspecified limitations; and
 - (iv) The service agreement must use language that clearly grants power of attorney to the service company, such as the words "power of attorney" or "attorney-in-fact"; and
- (H) Contain only those provisions for workers' compensation activities that are allowed in Oregon, subject to the following:
- (i) The director may approve an agreement that contains provisions for activities not allowed in Oregon if the agreement or an addendum provides that any services or provisions not allowed under Oregon workers' compensation law will not be applied when processing Oregon claims; and
 - (ii) The director may require existing agreements that contain provisions for activities not allowed in Oregon to be amended accordingly;
- (c) Each service company must notify the director of its business in Oregon, subject to the following:
- (A) The notice must include the service company's location, mailing address, telephone number, email address, and any other contact information requested by the director;
 - (B) The notice must be filed before the insurer begins using a place of business operated by the service company as a claims processing location; and
 - (C) The service company may use [Form 4929](#), "Service Company's Notification of Business in Oregon," to satisfy the requirements of this subsection; and
- (d) The insurer or service company must notify the director of a change in any of the information required under subsection (4)(c) of this rule, subject to the following:
- (A) The notice must be filed at least 30 days before the effective date of the change; and
 - (B) The insurer may use [Form 5215](#), "Service Company Contact Update," to satisfy the requirements of this subsection.

(5) Limit on claims processing locations.

The insurer may not have more than eight Oregon claims processing locations at any time. For the purposes of this section:

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

- (a) Each of the following is considered to be one claims processing location:
- (A) Each physical location where the insurer processes claims or maintains records; and
 - (B) Each physical location where a service company processes the insurer's claims or maintains records; and
- (b) If more than one entity, including the insurer or a service company, processes claims at the same physical location, each entity must be counted as a separate claims processing location.

(6) Changes in claims processing locations.

If an insurer intends to change the location where claims are processed or records of claims are stored, the insurer must, at least 10 days before the change is effective:

- (a) Provide notice of the change to any worker, the estate of any deceased worker, or any worker's beneficiary, with an open or active claim that will be processed at the new location, subject to the following:
- (A) The notice must include contact information for the new claims processing location, including the name and title of a contact person, telephone number, email address, and mailing address; and
 - (B) The insurer must send a copy of the notice to the worker's attorney, if the worker is represented, and to the worker's attending physician;
- (b) Provide notice of the change to the director, subject to the following:
- (A) The notice must include:
 - (i) Contact information for the current claims processing location, including the name of the claims processor, the name and title of a contact person, mailing address, telephone number, and email address;
 - (ii) Contact information for the new claims processing location, including the name of the claims processor, the name and title of a contact person, street and mailing address, if different, telephone number, and email address;
 - (iii) The effective date of the transfer; and
 - (iv) Any other information requested by the director; and
 - (B) The notice must specify if all or a portion of the insurer's claims will be transferred, and if closed and denied claims will be included. If only a portion of the insurer's claims will be transferred, the notice must include a listing of the claims being transferred that identifies, for each claim:
 - (i) The underwriting insurer;
 - (ii) The employer;
 - (iii) The claimant's name;
 - (iv) The date of injury; and

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

(v) The sending processor's claim number; and

(c) The insurer may use [Form 5042](#), "Claim Move Notice," to satisfy the requirements of this section.

~~(7) Civil penalties.~~

~~The director may assess a civil penalty against an insurer that does not comply with the requirements of this rule.~~

Statutory authority: ORS 731.475 and 656.726(4)

Statutes implemented: ORS 731.475

Hist: Amended 11/14/18 as WCD Admin. Order 18-061, eff. 1/1/19

[Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0120 Records Insurers Must ~~Keep in Oregon~~Maintain; Removal and Disposition

(1) ~~Claims r~~Records insurers must keep in Oregon maintain.

Each insurer is required to ~~keep-maintain~~ the following records of ~~Oregon claims for compensation~~Oregon workers' compensation claims in this state, and to make ~~those the~~ records available at an Oregon claims processing location, and to provide the director access to the records to the director upon request:

- (a) Written records used and relied upon in processing each claims;
- (b) A written record of all payments made as a result of any claim including documentation of:
 - (A) The amount of the payment;
 - (B) The date the payment was issued;
 - (C) The date the payment was mailed or delivered; and
 - (D) An explanation of the time period between the date the payment was issued and the date the payment was mailed or delivered, if any;
- (c) Written records of the approval or denial of claims for supplemental temporary disability benefits under ORS 656.210(5);
- (d) Written records that show its insured employers have complied with ORS 656.017; and
- (e) Written records, or copies of records, of claims processed by prior service companies.

(2) ~~Removal of claims records.~~Availability of records.

An insurer ~~may~~must remove the following make records available by one or more of the following methods from this state, under the conditions described in this section:

- (a) By making the records electronically accessible from an Oregon claims processing location in real time.
- (b) By keeping physical copies of the records at an Oregon claims processing location; or

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

(c) By archiving physical copies of the records at a location other than an Oregon claims processing location, under the following conditions:

- (~~a~~**A**) Records of a denied claim may be ~~removed from this state~~archived after all ~~the~~ appellate procedures have been exhausted and the denial is final by operation of law; and
- (~~b~~**B**) Records of any claim for a compensable injury, including a denied claim that is found to be compensable, may be ~~removed from this state~~archived after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur.

(3) Destruction of claims records.

The insurer may destroy claims records when the insurer can verify that all potential for benefits to the worker or the worker's beneficiaries is gone.

(4) Proof of coverage records insurer must keep in Oregon.

The records relating to proof of coverage that insurers are required to ~~keep~~make available in ~~the state~~Oregon include:

- (a) A written record of each workers' compensation insurance policy and related endorsements, reinstatements, or cancellations issued as required under the workers' compensation law;
- (b) Written records of premiums due and premiums collected by the insurer from its insured employers as a result of coverage issued under the workers' compensation law; and
- (c) Written records that segregate and show specifically for each employer the amounts due from the employer and all money collected and paid by the insurer for premiums for insurance coverage, premium assessments, and any other moneys due the director or required to be paid to the director.

(5) Disposal of proof of coverage records.

If all payments have been made, proof of coverage records may be disposed of after the later of:

- (a) The next examination of the insurer by the Division of Financial Regulation under ORS 731.300; or
- (b) January 1 of the year following three calendar years after the cancellation or nonrenewal of the workers' compensation insurance policy.

Statutory authority: ORS 731.475, and 656.726(4)

Statutes implemented: ORS 731.475

Hist: Amended 11/14/18 as WCD Admin. Order 18-061, eff. 1/1/19

Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

SELF-INSURED EMPLOYERS

436-050-0165 Security Deposit Requirements**(1) Adoption of standards.**

The director adopts, by reference, the International Standby Practices 1998 (ISP98), ICC Publication No. 590.

(a) This publication may be purchased from the International Chamber of Commerce website at <https://2go.iccwbo.org/>; and

(b) Copies of this publication are available for review during regular business hours at the Workers' Compensation Division, 350 Winter Street NE, Salem OR 97301.

(2) Required security deposit.

Each self-insured employer is required to provide a security deposit that is acceptable to the director as detailed in [Bulletin 147](#). Under the conditions and requirements of this rule, the director may accept:

(a) An irrevocable standby letter of credit (ISLOC); or

(b) A surety bond.

(3) Irrevocable standby letters of credit.

An ISLOC may be approved by the director as all or part of the security deposit. The director may approve the ISLOC under the following conditions:

(a) The ISLOC must be issued or confirmed by an Oregon state-chartered bank or a federally chartered bank from which funds will be immediately payable on demand;

(A) Except for federally chartered instrumentalities of the United States operating under the authority of the Farm Credit Act of 1971, as amended, the bank issuing the ISLOC must, at the time of issuance, have a long-term certificate of deposit rating of:

(i) "Aaa", "Aa", or "A" in the current monthly edition of "Moody's Statistical Handbook" prepared by Moody's Investors Service Inc., New York; or

(ii) "AAA", "AA" or "A" in the current quarterly edition or monthly supplement of "Financial Institutions Ratings" prepared by Standard & Poor's Corporation, New York;

(B) An ISLOC issued by a bank that does not meet the rating requirement of paragraph (A) at the time of issuance will only be accepted with a confirming ISLOC issued by an Oregon state-chartered bank or federally chartered bank that meets the rating requirement of paragraph (A). The confirming ISLOC must state that the confirming bank is primarily obligated to pay on demand the full amount of the ISLOC regardless of reimbursement from the bank whose ISLOC is being confirmed;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

- (C) If a bank's rating falls below the rating requirement of paragraph (A) subsequent to the issuance of the ISLOC, the self-insured employer must, within 60 days of the publication of the lower rating:
- (i) Replace the ISLOC with a new ISLOC issued by an Oregon state-chartered bank or a federally chartered bank with an acceptable rating;
 - (ii) Have the ISLOC confirmed by an Oregon state-chartered bank or a federally chartered bank that has an acceptable rating;
 - (iii) Replace the ISLOC with a surety bond of equal amount that is approved by the director as substitute security, if the surety bond covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC; or
 - (iv) Obtain a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5), if the certification of the self-insured employer has been canceled or revoked;
- (b) [Form 3640](#), "Irrevocable Standby Letter of Credit," must be used for the ISLOC;
- (c) The ISLOC must be issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;
- (d) The ISLOC must state that it will be automatically extended, without amendment, for one year from the expiration date or any subsequent expiration date, unless the bank gives the director written notice, by registered mail or overnight delivery, at least 60 days before the expiration date, that the bank has elected not to extend the ISLOC for another period;
- (e) The ISLOC must state that if the issuing bank or any confirming bank is closed at the time of expiration of the ISLOC for any reason that would prevent delivery of a demand notice during its normal hours of operation, the ISLOC will be automatically extended for a period of 30 days commencing on the next day of operation;
- (f) The ISLOC must be able to be called immediately if:
- (A) The self-insured employer has defaulted in payment of its workers' compensation liabilities or obligations, or in payments due to the director under ORS chapter 656;
 - (B) The self-insured employer has filed for bankruptcy;
 - (C) The self-insured employer has failed to renew the ISLOC or provide acceptable substitute security at least 15 days before the expiration date of the ISLOC; or
 - (D) The self-insured employer has failed to provide additional or replacement security after being ordered to do so by the director, notwithstanding written notice to the self-insured employer;
- (g) The funds provided by the ISLOC must be available by presentation of the beneficiary's sight draft drawn on the issuing bank, payable within three business days, when accompanied by one of the statements contained in subsection (f), signed by the director;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

- (h) The ISLOC must not be subject to any qualifications or conditions by the issuing bank or confirming bank and must state that it is each bank's individual obligation, which is in no way contingent upon reimbursement;
- (i) The ISLOC must state that:
- (A) The funds provided by the ISLOC are not construed to be an asset of the self-insured employer; and
 - (B) If legal proceedings are initiated by any party with respect to the payment of any ISLOC, it is agreed that such proceedings will be subject to Oregon courts and Oregon law;
- (j) The ISLOC must state that payment of any amount under the ISLOC will be made by wire transfer to a department account with the State Treasurer at a designated bank. Wire transfers must be in the name of the "Department of Consumer and Business Services In Trust For [the legal name of the certified self-insured employer]";
- (k) The ISLOC must conform to and reference the International Standby Practices 1998 (ISP98), ICC Publication No. 590;
- (l) The ISLOC must state that all bank charges for the ISLOC will be for the account of the applicant;
- (m) The ISLOC must state that any amendment to the ISLOC must be approved by the beneficiary before the amendment is effective;
- (n) The self-insured employer that submits the ISLOC must provide an accompanying [Form 3529](#), "Memorandum of Understanding," affirming the self-insured employer's acceptance of the following:
- (A) The ISLOC is provided to the director in place of, or in addition to, a surety bond or other form of security acceptable to the director under this rule;
 - (B) The ISLOC will be automatically extended without amendment for one year from the expiration date, or any subsequent expiration date, unless, at least 60 days before the expiration date, the bank notifies the director in writing that the ISLOC will not be renewed;
 - (C) The ISLOC may be replaced with an ISLOC or surety bond of equal amount that is accepted by the director as substitute security, or a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5), if the new ISLOC, surety bond, or policy of paid-up insurance covers all workers' compensation liabilities and obligations that would have been covered by the ISLOC;
 - (D) The ISLOC can be called immediately, at the director's discretion, if the director receives notice that the ISLOC will not be renewed; if the self-insured employer fails to pay its workers' compensation liabilities, obligations, or payments due to the director under ORS chapter 656; if the self-insured employer files bankruptcy; if the self-insured employer fails to renew the ISLOC or provide acceptable substitute security at least fifteen days before the expiration date of the ISLOC; or if the director has ordered the self-insured employer to provide additional or replacement security,

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

and neither has been provided, notwithstanding written notice to the self-insured employer; and

(E) If legal proceedings are initiated by any party with respect to payment of any ISLOC, the proceedings will be subject to the jurisdiction of Oregon courts and application of Oregon law.

(4) Surety bonds.

A surety bond may be approved by the director as all or part of the security deposit.

(a) The director may approve the surety bond under the following conditions:

(A) The surety bond must be issued by a surety company authorized under ORS chapter 731 to transact surety business in Oregon;

(B) The surety company or its parent must have and maintain an acceptable credit rating in accordance with the following:

(i) Standard and Poor's Insurer Financial Strength Rating of A or better; or

(ii) A.M. Best Company Financial Strength Rating of B+ or better;

(C) [Form 824](#), "Surety Bond," must be used for the surety bond;

(D) The surety bond must be issued under the legal name or assumed business name of the self-insured employer as registered with the Oregon Secretary of State;

(E) The surety bond must be continuous in form;

(F) The surety bond must state that it may only be terminated by the surety company by giving the director and the Principal written notice. The notice must state that the termination will be effective on a date not less than thirty days after the date the notice is received by the director. Termination of a surety bond in no way limits the liability of the surety for defaults of the Principal's liability or obligations under ORS chapter 656 before the effective date of the termination;

(G) The surety bond must state that the liability of the surety company may only be discharged in the event that the surety bond is released in writing by the director. The director may release a surety bond when:

(i) The Principal provides substitute security that is accepted by the director in lieu of the surety bond to be released, covering all past, present, existing, and potential liability of the Principal under ORS chapter 656, in an amount required by the director; or

(ii) If the certification of the self-insured employer has been canceled or revoked, the self-insured employer obtains a policy of paid-up insurance that is accepted by the director in accordance with OAR 436-050-0200(5).

(H) The surety bond and all surety bond riders must be executed by the surety company's attorney-in-fact. The attorney-in-fact's appointment and power of attorney must accompany the surety bond and all riders submitted. The power of attorney must

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

authorize the attorney-in-fact to execute the surety bond in the amount of the penal sum of the bond.

(b) [Form 1810](#), "Surety Bond Rider" must be used for all department-required increases or authorized decreases in the penal sum of the surety bond and all changes to the name of the Principal. The surety bond rider is not effective until it is accepted by the department.

(c) The surety bond must be replaced by the self-insured employer with an acceptable type of security deposit within 30 days after notice from the department that the Surety has been placed in conservatorship, is seized, declares insolvency, or has a current credit rating below the ratings required in subsection (a)(B).

(5) Government securities, certificates of deposit, or time deposit accounts.

Government securities, certificates of deposit, or time deposit accounts will not be accepted as security deposits for certified self-insured employers who must increase their security deposit or for employers whose self-insurance certification was granted after January 1, 2004.

(a) Government securities, certificates of deposit, or time deposit accounts that were accepted by the director as a self-insured employer's or a self-insured employer group's required security deposit before January 1, 2004, may remain as the security deposit until the maturity date of those investments. At that time, the government securities, certificates of deposit, or time deposit accounts pledged to the department as security deposits must be replaced by a surety bond or ISLOC acceptable to the director.

(b) A self-insured employer that has government securities, certificates of deposit, or time deposit accounts as all or part of its security deposit must complete [Form 4023](#), "Security Agreement and Notice to Intermediary," granting the department a security interest in and control over those financial assets.

Statutory authority: ORS 656.430 and 656.726(4)

Statutes implemented: ORS 656.430

Hist: Amended 12/17/19 as Admin. Order 19-057, eff. 1/1/20

[Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0180 Determination of Amount of Self-Insured Employer's Deposit; Effective Date of Order to Increase Deposit

(1) Indicated security deposit.

Except for self-insured cities, counties, or qualified self-insured employer groups who are exempted under ORS 656.407(3) and OAR 436-050-0185, each self-insured employer is required to maintain a security deposit with the director in an amount determined by the director, subject to the following:

(a) The deposit will not be less than the greater of:

(A) \$100,000;

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

- (B) Future claim liability, including losses incurred but not reported (IBNR), a claims processing administrative cost, and the anticipated assessments payable to the director for the employer's next fiscal year; or
- (C) The annual incurred losses for the self-insured employer's last fiscal year, including IBNR, a claims processing administrative cost, and anticipated assessments payable to the director for the employer's next fiscal year;
- (b) If the employer is applying for self-insurance, the amount of the initial deposit must not be less than the greater of:
- (A) The anticipated assessments payable to the director for the employer's next fiscal year, plus an amount equal to 65 percent of the annual premium the employer would pay if carrier-insured using the applicable occupational base rate premium, as such rate is applied to the anticipated payroll of the employer's Oregon operations for the employer's next fiscal year;
- (B) \$300,000 plus \$30,000 additional for each \$100,000 the employer's net worth is below \$2 million; or
- (C) The amount of the approved self-insured retention level for the employer's excess workers' compensation insurance;
- (c) Assessments payable to the director referred to in this section include moneys and assessments due under ORS 656.506, 656.612, and 656.614;
- (d) Claims processing administrative costs will be determined by developing a percentage rate to be applied against the employer's unpaid losses;
- (A) The rate will be based on the information contained in Schedule P, Part ID [\(Workers' Compensation\)](#) of the Annual Statement for the previous calendar year as reported to the Insurance Commissioner by SAIF Corporation and the 20 private insurers who had the highest earned premium reported for the preceding calendar year; and
- (B) The rate will be computed annually to be effective for the subsequent fiscal year. The rate will be 105 percent of the median of ratios determined as follows for each of these insurers:
- (i) "**Loss expenses unpaid**" for losses incurred in the latest eight years, divided by
- (ii) "**Losses unpaid**" for losses incurred in the latest eight years; and
- (e) Under this section, "Incurred but not reported" (IBNR) will be calculated by applying a loss development factor determined by the director against the employer's incurred losses.

(2) Financial strength adjustment.

If the self-insured employer received a financial strength rating equal to "moderate" under OAR 436-050-0150(5) or OAR 436-050-0260(12), the amount of the deposit determined under section (1) will be increased by the following percentage factors:

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

- (a) 12 total combined points = no change in calculated deposit;
- (b) 11 total combined points = no change in calculated deposit;
- (c) 10 total combined points = 5%;
- (d) 9 total combined points = 10%;
- (e) 8 total combined points = 15%; or
- (f) 7 total combined points = 20%.

(3) Certified actuarial study.

A self-insured employer may request for its security deposit amount to be determined based on a recommended loss reserve level established by a certified actuarial study in place of the calculations under sections (1) and (2) of this rule. The director may base a self-insured employer's security deposit amount on a certified actuarial study under the following conditions:

- (a) The actuarial study must be certified by an actuary who is a member in good standing of the American Academy of Actuaries;
- (b) The actuarial study must be submitted to the director within seven days after the date of the director's notice establishing the security deposit amount calculated under sections (1) and (2) of this rule;
- (c) The actuarial study must include an estimate or range of estimates of future claim liability and state what provisions for adverse claim development are included in these estimates;
- (d) The actuarial study must identify the confidence levels associated with the recommended loss reserve level or loss reserve range;
- (e) The actuarial study must include a statement of future claim liability, including the employer's incurred but not reported (IBNR) losses;
- (f) Subject to the minimum requirements of ORS 656.407 and this rule, upon the director's review and acceptance of the study, the amount of the security deposit will be based on:
 - (A) The actuarially sound recommended loss reserve level if a single estimate is provided; or
 - (B) The 75% confidence level estimate, if an actuarially sound loss reserve range is provided; and
- (g) If there is probable cause to believe the recommended loss reserve level or range is not actuarially sound, the director will determine the security deposit under sections (1) and (2) of this rule. Probable cause includes, but is not limited to:
 - (A) The actuarial study not containing a statement by the actuary that the recommended loss reserve level or range is actuarially sound;

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

(B) The actuarial study containing a disclaimer regarding the actuary's qualifications or ability to determine the adequacy of the loss reserve level for current or future liabilities; or

(C) The recommended loss reserve level or entire recommended loss reserve range being less than the 75 percent confidence level estimate established in the actuarial study.

(4) Additional factors for security deposit amount.

In determining the amount of the self-insured employer's security deposit the director will take the following factors into consideration:

- (a) The financial ability of the employer to pay compensation and other payments due;
- (b) The employer's probable continuity of operation;
- (c) The employer's financial viability, as determined by the director under OAR 436-050-0150 or OAR 436-050-0260;
- (d) Retention and limitation levels of the employer's excess insurance in relation to the employer's financial status;
- (e) Changes in the employer's business including, but not limited to, mergers or acquisitions, changes in employment level, nature of employment, incurred claims costs, or material growth in self-insured exposure;
- (f) The balance of the Self-Insured Employer Adjustment Reserve or the Self-Insured Employer Group Adjustment Reserve; and
- (g) The employer's credit rating issued by a nationally recognized statistical ratings organization;

(5) Time frame for compliance.

A self-insured employer must comply with an order of the director to the self-insured employer to increase the amount of its deposit within 30 days of the order. Failure to comply with this rule may result in the assessment of civil penalties, revocation of the employer's certification of self-insurance, or both.

Statutory authority: ORS 656.407, and 656.726(4)

Statutes implemented: ORS 656.407

Hist: Amended 12/14/17 as WCD Admin. Order 17-061, eff. 1/1/18

[Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0210 Notice of Self-Insurer's Place of Business in State; Records Self-Insured Must ~~Keep in Oregon~~ Maintain

(1) Oregon claims processing location required.

Except as described in section (4) of this rule and OAR 436-050-0230, every self-insured employer must establish and maintain at least one designated Oregon claims processing location as required by ORS 656.455, subject to the following:

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

(a) The self-insured employer must conduct all claims processing activities necessary to meet the requirements of ORS chapter 656 and OAR chapter 436 from its designated claims processing locations, including, but not limited to:

(A) Processing claims;

(B) ~~Maintaining~~ Making available all records required under OAR 436-050-0220; and

(C) Responding to specific claims processing inquiries;

(b) At the director's request, the self-insured employer must:

(A) Make claims processing locations ~~must be made~~ accessible during regular business hours or other reasonable times to accommodate periodic audits and examination of records; ~~or~~ and

(B) Provide the director electronic access to the records to be audited or examined.

(c) The self-insured employer may ~~not process or maintain records of~~ claims subject to ORS chapter 656 remotely. As used in this subsection, to "process claims remotely" means to process claims outside of a self-insured employer's at any Oregon claims processing location, including at the place of residence of an employee of the self-insured employer, as directed from the Oregon claims processing location. location outside of this state, subject to the following:

(A) The self-insured employer may not process claims at places of business outside of Oregon that are maintained or operated by the self-insured employer or a service company, except as follows;

(i) The self-insured employer may receive claims reports at locations outside of the state if claims are forwarded to an Oregon claims processing location for processing;

(ii) ~~B~~ Payments may be made from outside of Oregon as directed from the Oregon claims processing location; and

(iii) ~~C~~ The self-insured employer may, with prior approval of the director, have one location, in or out of state, for maintaining payroll records pertaining to premium assessments and other assessments and contributions.

(B) The director may suspend a self insured employer's authority to process claims remotely from its designated claims processing locations, subject to the following:

(i) The director may suspend a self insured employer's authority to process claims remotely when:

(I) The director finds the self insured employer has repeatedly violated ORS chapter 656 or OAR chapter 436; and

(II) The director has reason to believe that the violations are related to the self insured employer's practice of processing claims remotely.

(ii) The director will not suspend a self insured employer's authority to process claims remotely until the self insured employer has been given notice and the

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

opportunity to be heard through a show-cause hearing with the director. During the show-cause hearing, the self insured employer will be provided an opportunity to:

(I) Present evidence regarding the proposed order to suspend the self insured employer's authority to process claims remotely; and

(II) Give reason why the self insured employer should be permitted to continue processing claims remotely.

(iii) If the director suspends a self insured employer's authority to process claims remotely, the self insured employer may not process claims remotely for a specified period of time, up to two years.

(iv) The self-insured employer may request the director restore its authorization by submitting a plan demonstrating its ability and commitment to comply with ORS chapter 656 and OAR chapter 436.

(v) A proposed and final order of suspension issued under this rule is a preliminary order subject to revision by the director, and may be appealed under OAR 436-050-0008.

(2) Notice of self-insured employer's claims processing location.

The self-insured employer must give the director notice of its designated claims processing locations, subject to the following:

(a) The notice must be provided upon application for certification as a self-insured employer; and

(b) The notice must identify:

(A) The self-insured employer's principal place of business, including its street and mailing addresses, telephone number, and a general email address that is monitored on a regular basis, where the director can direct general inquiries;

(B) Contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues;

(C) If the self-insured employer uses more than one claims processing location, or locations operated by service companies as described in section (4) of this rule:

(i) The name of each service company, if applicable;

(ii) The street and mailing addresses of each claims processing location; and

(iii) The name, title, phone number, and email address of a contact person at each claims processing location; and

(D) Any other information requested by the director; and

(c) The information provided under this section must reasonably lead an inquirer to an Oregon certified claims examiner who can respond to inquiries regarding workers'

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

compensation policies, claim filing, claims processing, and claims processing location information within 48 hours, not including weekends or legal holidays.

(3) Changes in place of business.

The self-insured employer must notify the director of a change in any of the information required under section (2) of this rule, subject to the following:

- (a) The notice must be filed at least 30 days before the effective date of the change; and
- (b) The self-insured employer may use [Form 5188](#), "Insurer Contact Update," to satisfy the requirements of this section.

(4) Service companies.

In lieu of, or in addition to, establishing its own claims processing locations in this state, the self-insured employer may use Oregon claims processing locations operated by service companies to satisfy the requirements of section (1) of this rule. If a self-insured employer elects to use claims processing locations operated by one or more service companies with respect to all or any portion of its business:

- (a) Each service company must be incorporated in or authorized to do business in Oregon;
- (b) The self-insured employer must provide the director with a copy of the service agreement between the self-insured employer and each service company for approval. The director must approve the service agreement before the service company begins processing the self-insured employer's Oregon claims, regardless of the agreement's effective date. To be approved, the service agreement must:
 - (A) Be an agreement for claims processing services between the self-insured employer and a service company, and must not be between any other third parties;
 - (B) Identify the self-insured employer by name, and specify the self-insured employer's legal or assumed business name as registered with the Oregon Secretary of State;
 - (C) Identify the service company by name;
 - (D) Describe the claims processing services to be provided;
 - (E) Identify the effective date of the agreement;
 - (F) Identify the termination date of the agreement, if any;
 - (G) Grant the service company a power of attorney to act for the self-insured employer in workers' compensation coverage and claims proceedings under ORS chapter 656, subject to the following:
 - (i) The power of attorney must be effective the same date of the service agreement;
 - (ii) The power of attorney must not be revocable before all claims processing services provided under the service agreement have concluded;

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

(iii) The power of attorney must be applicable to all claims processed under the agreement, and may not have unspecified limitations; and

(iv) The service agreement must use language that clearly grants power of attorney to the service company, such as the words “power of attorney” or “attorney-in-fact”; and

(H) Contain only those provisions for workers’ compensation activities that are allowed in Oregon; subject to the following:

(i) The director may approve an agreement that contains provisions for activities not allowed in Oregon if the agreement or an addendum provides that any services or provisions not allowed under Oregon workers’ compensation law will not be applied when processing Oregon claims; and

(ii) The director may require existing agreements that contain provisions for activities not allowed in Oregon to be amended accordingly;

(c) Each service company must notify the division of its business in Oregon, subject to the following:

(A) The notice must include the service company’s location, mailing address, telephone number, email address, and any other contact information requested by the director;

(B) The notice must be filed before the self-insured employer begins using a place of business operated by the service company as a claims processing location; and

(C) The service company may use [Form 4929](#), “Service Company’s Notification of Business in Oregon,” to satisfy the requirements of this subsection; and

(d) The self-insured employer or service company must notify the director of a change in any of the information required under subsection (4)(c) of this rule, subject to the following:

(A) The notice must be filed at least 30 days before the effective date of the change; and

(B) The self-insured employer or service company may use [Form 5215](#), “Service Company Contact Update,” to satisfy the requirements of this subsection.

(5) Limit on claims processing locations.

The self-insured employer may not have more than three claims processing locations at any time. For the purposes of this section:

(a) Each of the following is considered to be one claims processing location:

(A) Each physical location where the self-insured employer processes claims or maintains records; and

(B) Each physical location where a service company processes the self-insured employer’s claims or maintains records; and

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**Proposed** EMPLOYER/INSURER COVERAGE RESPONSIBILITY

(b) If more than one entity, including the self-insured employer or a service company, processes claims at the same physical location, each entity must be counted as a separate claims processing location.

(6) Change in claims processing locations.

If a self-insured employer intends to change the location where claims are processed or records of claims are stored, the self-insured employer must, at least 10 days before the change is effective:

(a) Provide notice of the change to any worker, the estate of any deceased worker, or any worker's beneficiary with an open or active claim that will be processed at the new location, subject to the following:

(A) The notice must include contact information for the new claims processing location, including the name and title of a contact person, telephone number, email address, and mailing address; and

(B) The self-insured employer must send a copy of the notice to the worker's attorney, if the worker is represented, and to the worker's attending physician.

(b) Provide notice of the change to the director, subject to the following:

(A) The notice must include:

(i) Contact information for the current claims processing location, including the name of the claims processor, the name and title of a contact person, mailing address, telephone number, and email address;

(ii) Contact information for the new claims processing location, including the name of the claims processor, the name and title of a contact person, street and mailing address, if different, telephone number, and email address;

(iii) The effective date of the transfer; and

(iv) Any other information requested by the director; and

(B) The notice must specify if all or a portion of the self-insured employer's claims will be transferred, and if closed and denied claims will be included. If only a portion of the self-insured employer's claims will be transferred, the notice must include a listing of the claims being transferred that identifies, for each claim:

(i) The claimant's name;

(ii) The date of injury; and

(iii) The sending processor's claim number; and

(c) The self-insured employer may use [Form 5042](#), "Claim Move Notice," to satisfy the requirements of this section.

~~(7) Civil penalties.~~

~~The director may assess a civil penalty against a self-insured employer that does not comply with the requirements of this rule.~~

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

Statutory authority: ORS 656.455, and 656.726(4)

Statutes implemented: ORS 656.455

Hist: Amended 11/14/18 as WCD Admin. Order 18-061, eff. 1/1/19

[Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0220 Records Self-Insured Employer Must ~~Keep in Oregon~~Maintain; Period to be Retained, Removal and Disposition

(1) ~~Claims +~~Records self-insured employers must ~~keep in Oregon~~maintain.

Each self-insured employer is required to keep-maintain the following records in ~~this state, Oregon and~~, to make ~~those-the~~ records available at an Oregon claims processing location, and to provide the director access to the records ~~to the director~~ upon request:

- (a)** Written records necessary to ensure compliance with ORS 656.506, 656.612, 656.614, and 656.622 including:
 - (A)** A record of payroll by National Council on Compensation Insurance classification; and
 - (B)** Complete records of all assessments, employer and employee contributions, and all such money due the director;
- (b)** Written records relating to its safety and health program as required by ORS 656.430(10) and OAR 437-001;
- (c)** Written records used and relied upon in processing claims;
- (d)** A written record of all payments made as a result of any claim, including documentation of:
 - (A)** The amount of the payment;
 - (B)** The date the payment was issued;
 - (C)** The date payment was mailed or delivered; and
 - (D)** An explanation of the time period between the date the payment was issued and the date the payment was mailed or delivered, if any;
- (e)** A written record of all reimbursements and recoveries received on each claim;
- (f)** A written record of the approval or denial of claims for supplemental temporary disability benefits under ORS 656.210(5);
- (g)** A summary sheet for each claim showing all payments made, separated into disability, medical, and vocational assistance payments showing all reimbursements made and cumulative totals, subject to the following:
 - (A)** The record of disability payments should be limited to statutory benefits and not include any additional employer obligations; and
 - (B)** Expenses must not be included in any of the three columns required on the summary sheet. "Expenses" are defined in National Council on Compensation

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

Proposed EMPLOYER/INSURER COVERAGE RESPONSIBILITY

Insurance, Workers' Compensation Statistical Plan, Part IV (available from NCCI, www.ncci.com, 800-622-4123); and

(h) Written records, or copies of records, of claims processed by prior service companies.

(2) ~~Removal~~ Availability of ~~claims~~ records.

A self-insured employer ~~may remove the following records, under the conditions described in this section~~ must make records available by one or more of the following methods:

(a) By making the records electronically accessible from an Oregon claims processing locations in real time;

(b) By keeping physical copies of the records at an Oregon claims processing location;

(c) By archiving physical copies of the records at a location other than an Oregon claims processing location, under the following conditions:

~~(a)~~ (A) Records of a denied claim may be ~~removed from this state~~ archived after all the appellate procedures have been exhausted and the denial is final by operation of law;

~~(b)~~ (B) Records of any claim for a compensable injury, including a denied claim that is later found to be compensable, may be ~~removed from this state~~ archived after the expiration of the aggravation rights or not less than one year following the final payment of compensation, whichever is the last to occur; and

~~(c)~~ (C) If administrative or judicial review is requested, the claim records may not be ~~removed from this state~~ archived or disposed of until the review is concluded and the time for an appeal from such review has expired, or at least one year after final payment of compensation has been made, whichever is the last to occur. ~~and~~

(3) Destruction of claims records.

The self-insured employer may destroy claim records when the self-insured employer can verify that all potential for benefits to the injured worker or the worker's beneficiaries is gone.

(4) Retention of payroll records required under this rule.

Payroll records retained under subsection (1)(a) of this rule may be ~~removed from the state~~ archived or destroyed at the end of three full calendar years after the calendar year in which the money was remitted.

Statutory authority: ORS 656.455, and 656.726(4)

Statutes implemented: ORS 656.455

Hist: Amended 11/14/18 as WCD Admin. Order 18-061, eff. 1/1/19

Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0230 Out-of-State Recordkeeping and Claims Processing by Self-Insured Employer; Conditions and Procedure for Permit; Revocation

(1) Permission to keep records and process claims outside of Oregon.

Notwithstanding OAR 436-050-0210 and 436-050-0220, with the prior approval of the director a self-insured employer may ~~keep claims records and~~ process claims and make

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

[claims records available](#) at a [claims processing](#) location outside ~~this state~~[Oregon](#), under the following conditions:

- (a) The self-insured employer must submit a written application to the director;
 - (A) The application must contain the reasons for the request and the mailing address, telephone number, email address and any other contact information of the location where the records will be kept and the claims processed; and
 - (B) The application must provide ~~the director~~ contact information for a designated person or position within the company who will assure payment of penalties and resolution of collections issues resulting from orders issued by the director, and a company email address that is monitored on a regular basis;
- (b) Upon receipt, the director will review the application and notify the employer if the request has been approved or denied. If the request has been denied, the director will notify the employer of the reasons for the denial; and
- (c) The director will not grant permission to any self-insured employer that has committed acts or engaged in a course of conduct that would be grounds for revocation of permission or that are contrary to any of the provisions of this rule.

(2) Requirements.

A self-insured employer that keeps claims records and processes claims at a [claims processing](#) location outside ~~this state~~[Oregon](#) must:

- (a) Process claims and make payment of compensation in an accurate and timely manner;
- (b) Make reports to the director promptly as required by ORS chapter 656 and ~~the director's administrative rules~~[OAR chapter 436](#);
- (c) Pay to the director promptly all assessments and other money as it becomes due;
- (d) Increase or decrease its security deposit promptly when directed to do so by the director under ORS 656.407(2);
- (e) Comply with the rules and orders of the director in processing and paying claims for compensation; and
- (f) Provide written records which have been removed from this state to the director as requested within a reasonable time not to exceed 14 days or as otherwise negotiated.

(3) Revocation of permission.

After notice given as required by ORS 656.455(2), permission granted under this rule will be revoked by the director if the employer has committed acts or engaged in a course of conduct that are in violation of any provisions of this rule.

Statutory authority: ORS 656.455, and 656.726(4)

Statutes implemented: ORS 656.455

Hist: Amended 11/28/16 as WCD Admin. Order 16-054, eff. 1/1/17

[Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION**

***Proposed* EMPLOYER/INSURER COVERAGE RESPONSIBILITY**

436-050-0300 Self-Insured Employer Group, Common Claims Fund

(1) Except for qualified self-insured employer groups approved by the director as exempt from security deposit requirements under OAR 436-050-0185, a self-insured employer group must establish and maintain, under the direction and control of the board of trustees and administrator, a common claims fund for the sole purpose of ensuring the availability of funds to make certain the prompt payment of all compensation and all other payments that may become due from such self-insured employer group under the workers' compensation law. This requirement does not apply in any year in which the director applies an incurred but not reported (IBNR) factor of greater than zero percent in the determination of the self-insured employer group's security deposit under OAR 436-050-0180.

(2) The common claims fund must be maintained in an account held by an Oregon state chartered or a federally chartered bank. Government subdivisions certified as a self-insured employer group may also maintain the common claims fund in a "Local Government Investment Pool" account held by the Office of the State Treasurer.

(3) Except as provided in section (6) of this rule, the balance of the common claims fund must be maintained in an amount at least equal to 30 percent of the average of the group's paid losses for the previous four years. The full sum of the required common claims fund balance must be maintained at all times.

(4) The director may require the self-insured group to increase the amount maintained in the common claims fund.

(5) By March 1 of each year, a self-insured employer group must provide the director with adequate documentation to validate the balance in the common claims fund or notice that the amount calculated under section (3) or (6) of this rule must be included in the determination of the self-insured employer group's security deposit under OAR 436-050-0180. The director may require a self-insured employer group to provide documentation of the common claims fund balance more frequently.

(6) For governmental subdivisions certified as a self-insured employer group, the balance of the common claims fund must be maintained in an amount at least equal to 60 percent of the average of the group's yearly paid losses for the previous four years.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.430

Hist: Amended 8/15/14 as WCD Admin. Order 14-059, eff. 9/15/14

Amended 11/28/16 as WCD Admin. Order 16-054, eff. 1/1/17

Amended xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-050-0500 Assessment of Civil Penalties

The director may assess a civil penalty under ORS 656.745(2) against an employer or insurer that violates ORS chapter 656, OAR 436-050, or an order of the director.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.745(2)

Hist: Adopted xx/xx/xx as Admin. Order 21-xxx, eff. 1/1/22

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION



**Claims Administration
Oregon Administrative Rules
Chapter 436, Division 060**

Proposed Effective Jan. 1, 2022

TABLE OF CONTENTS

Rule		Page
436-060-0005	Definitions	1
436-060-0015	Required Notice and Information	3
436-060-0017	Release of Claim Documents	4
436-060-0035	Supplemental Disability for Workers with Multiple Jobs at the Time of Injury	7
436-060-0180	Designation and Responsibility of a Paying Agent	12

Historical rules: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

OREGON ADMINISTRATIVE RULES
CHAPTER 436, DIVISION 060

NOTE: Revisions are marked as follows: new text | ~~deleted text~~.

436-060-0005 Definitions

Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 are hereby incorporated by reference and made a part of these rules. For the purpose of these rules unless the context requires otherwise:

(1) "**Aggravation**" means an actual worsening of the compensable conditions after the last award or arrangement of compensation that satisfies the requirements of ORS 656.273.

(2) "**Authorized nurse practitioner**" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(3) "**Board**" means the Workers' Compensation Board and includes its Hearings Division.

(4) "**Business days**" means Monday through Friday, excluding legal holidays. Legal holidays are those listed in OAR 436-060-0150(2).

(5) "**Date stamp**" means to stamp or display the initial receipt date and the recipient's name on a paper or electronic document, regardless of whether the document is printed or displayed electronically.

(65) "**Dependent**" means any of the relatives of a worker listed under ORS 656.005(10) who, at the time of an accident, depended in whole or in part for support on the earnings of a worker who dies as a result of an injury.

(76) "**Designated paying agent**" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

(87) "**Director**" means the Director of the Department of Consumer and Business Services or the director's designee.

(98) "**Disposition**" or "**claim disposition**" means the written agreement to release rights or obligations under ORS 656.236.

(109) "**Division**" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(110) "**Employer**" means a subject employer under ORS 656.023.

(124) "**Inpatient**" means a worker who is admitted to a hospital before and extending past midnight for treatment and lodging.

(132) "**Insurer**" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in Oregon;

ORDER NO. 21-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

or an employer or employer group certified under ORS 656.430 that meets the qualifications of a self-insured employer under ORS 656.407.

(143) "Mailing date," unless otherwise specified, means:

- (a) The date a document is postmarked;
- (b) The date automatically produced by electronic transmission (e.g., email or facsimile);
- (c) The date a hand-delivered document is received by the recipient; or
- (d) The date of a phone or in-person request, when allowed under these rules.

(154) "Physical rehabilitation program" means any services provided to a worker to prevent the compensable injury from causing continuing disability.

(165) "Regularly employed" means a worker is receiving a regular wage as defined in section (18) of this rule. For workers who are paid a daily wage, "regularly employed" means actual employment or availability for such employment.

(176) "Service company" means the contracted agent for an insurer authorized to process claims and make payment of compensation on behalf of the insurer.

(187) "Suspension of compensation" means a period of time where:

- (a) No temporary disability, permanent total disability, or medical and related service benefits accrue or are payable; and
- (b) Vocational assistance and payment of permanent partial disability benefits will be stayed.

(198) "Wages" is as defined in ORS 656.005(29) and, in these rules, is categorized as either irregular wages or regular wages. Wages do not include expenses incurred due to the job and reimbursed by the employer (e.g., meals, lodging, per diem, equipment rental).

(a) **"Irregular wages"** means a variable pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes but is not limited to:

- (A) Tips;
- (B) Commissions;
- (C) Monies paid on unscheduled or unpredictable intervals, including but not limited to workers who are seasonally employed, on call, paid hourly at varying hours, or paid by piece rate; and
- (D) The reasonable value of any in-kind considerations only if the considerations will not continue during the period of disability; and

(b) **"Regular wages"** means a constant and uniform pay rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, and it includes, but is not limited to, wages paid on a daily or weekly basis. Hourly wages may be considered regular if the same number of hours are worked each pay period.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(2019) "Wage earning agreement" means the verbal or written contract of hiring or terms of employment made between the worker and employer.

(219) "Written" means expressed in writing, including electronic transmission.

Statutory authority: ORS 656.726(4)

Statutes implemented: ORS 656.005 and 656.726(4)

Hist: Amended 7/17/18 as WCD Admin. Order 18-058, eff. 8/1/18

Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

[Amended xx/xx/xx as WCD Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0015 Required Notice and Information

(1) Notice to worker's attorney.

If a worker is represented by an attorney, and the attorney has given written notice of representation, the insurer must provide written notice to the worker's attorney before, or at the same time, as the insurer:

- (a) Requests the worker to submit to a medical examination;
- (b) Contacts the worker regarding any matter that may result in denial, reduction, or termination of the worker's benefits; or
- (c) Contacts the worker regarding any matter relating to the disposition of a claim under ORS 656.236.

(2) Penalty for failure to provide notice to worker's attorney.

The director may assess a civil penalty against an insurer that intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) Information provided to worker.

The insurer or service company must provide:

- (a) [Form 1138](#), "What happens if I'm hurt on the job?" to every worker who has a disabling claim with the first disability check or earliest written correspondence. For nondisabling claims, [Form 3283](#), "A Guide for Workers Recently Hurt on the Job," may be provided in place of Form 1138, unless the worker specifically requests Form 1138;
- (b) [Form 3283](#) to its insured employers. Form 3283 may be printed on the back of [Form 801](#);
- (c) [Form 3058](#), "Notice to Worker," or an equivalent form, to the worker with the initial notice of acceptance of the claim under OAR 436-060-0140(6). If an equivalent form is provided, it must include all of the information included on Form 3058; ~~and~~
- (d) The additional notices required under OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180; ~~and~~
- (e) [With the first disability check or earliest written correspondence, contact information that will:](#)

ORDER NO. 21-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(A) Reasonably lead the worker to an Oregon certified claims examiner during regular Oregon business hours; and

(B) Reasonably ensure that inquiries from the worker are responded to within 48 hours, not including weekends or legal holidays.

(4) Notice of change of processing location.

When the insurer changes claims processing locations, service companies, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, email address, and mailing address of the new claim processor.

(5) Notice of change in rate of compensation and benefit amounts.

When the insurer changes the rate of compensation, the wage used to calculate benefit amounts, or the method of calculation used to determine benefits, the insurer must provide a written explanation of any change to the worker and the worker's attorney, if any.

(6) Notice of wage used to calculate benefits at closure.

Before closure of a disabling claim the insurer must send a notice to the worker that:

- (a) Documents the wage upon which benefits were based;
- (b) Informs the worker that work disability, if applicable, will be determined when the claim is closed; and
- (c) Explains how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.

Statutory authority: ORS 656.331, 656.726(4), and 656.745
Statutes implemented: ORS 656.331, 656.726(4), and 656.745
Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17
Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20
Amended xx/xx/xx as WCD Admin. Order 21-xxx, eff. 1/1/22
See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0017 Release of Claim Documents

(1) For the purpose of this rule:

(a) "**Documents**" means the written records making up, or relating to, the worker's claim, including but not limited to:

(A) Medical records, including any correspondence to and from the medical experts who provide the reports;

(B) Vocational records, including any correspondence to and from the vocational experts who provide the reports;

(C) ~~Payment ledgers for both temporary disability and medical services~~ Records of all compensation paid;

(D) Payroll records;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(E) Recorded statements;

(F) [Investigative statements and investigative summaries](#);

(~~FG~~) Insurer generated records, excluding a claims examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any ~~privileged communications~~ [document not subject to discovery under OAR 438-007-0015](#);

(~~GH~~) All forms [and notices](#) on the claim ~~filed with the director~~ [required by ORS chapter 656 or OAR chapter 436](#);

(~~HJ~~) Notices of closure; and

(~~J~~) Electronic transmissions and correspondence between the insurer, service providers, worker, director, or board.

(b) Any documents generated or received by the insurer five or more business days before the mailing date of a request for copies of claims documents are considered to be in the insurer's or service company's possession, even if the documents have not reached the insurer's or service company's claim file.

(2) Date of receipt.

The insurer or service company must ~~display evidence of the initial date of receipt on date stamp~~ each document in its possession [on the date received](#).

~~(a) The evidence must include the month, day, year of receipt, and name of the company that received the document.~~

~~(b) Acceptable evidence under this section includes, but is not limited to, a machine produced date stamp or the data automatically produced by electronic transmission.~~

(3) Requests for claims documents.

The insurer or service company must provide, without charge, legible copies of documents in its possession relating to a claim, upon request of the worker, worker's attorney, worker's beneficiary, or beneficiary's attorney at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule.

(a) A request for copies of claim documents must be submitted to the insurer or service company, and copied simultaneously to the insurer's defense counsel, if known.

(b) Except as provided in OAR 436-060-0180, an initial request by anyone other than the worker or worker's beneficiary must be accompanied by an attorney retainer agreement or a medical release that has been signed by the worker.

(A) The signed medical release must be provided using [Form 2476](#), "Request for Release of Medical Records for Oregon Workers' Compensation Claim," or an equivalent form.

(B) Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws.

ORDER NO. 21-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

- (c) If the worker or beneficiary is represented by an attorney:
- (A) The documents must be mailed directly to the worker's or beneficiary's attorney;
 - (B) The insurer is not required to provide copies to both the worker or beneficiary and the attorney; however, the insurer must inform the worker or beneficiary that the documents were mailed to the attorney if the documents were requested by the worker or beneficiary; and
 - (C) If the worker or beneficiary changes attorneys, the insurer must provide the new attorney with copies upon request.
- (d) If the worker's or beneficiary's attorney makes an ongoing request for documents:
- (A) The insurer must provide all new documents received and generated by the insurer for 180 days after the initial mailing date under section (4) of this rule, or until a hearing is requested before the board; and
 - (B) The insurer must provide new documents to the worker's or beneficiary's attorney every 30 days. If the attorney requests that specific documents be sent sooner, those documents must be provided within the time frame specified in section (4) of this rule.
- (e) The insurer must provide to the worker or the worker's attorney the entire health information record in its possession, except the following may be withheld:
- (A) Information obtained from someone other than a health care provider under a promise of confidentiality and access to the information would likely reveal the source of the information;
 - (B) Psychotherapy notes;
 - (C) Information compiled for use in a civil, criminal, or administration action or proceeding; or
 - (D) Information that must be withheld under federal regulation.
- (f) If a hearing is requested before the board, the release of documents is controlled by OAR chapter 438 until the hearing request is withdrawn or the hearing record is closed, provided a request for documents is renewed.

(4) Format of documents.

The insurer may provide electronic or paper copies of documents requested under this rule, unless the worker, worker's attorney, worker's beneficiary, or beneficiary's attorney specifically requests paper copies.

(5) Time frame to provide documents.

The insurer must provide copies of documents requested under this rule within the following time frames:

- (a) For files that are not archived, documents must be mailed within 14 days of receipt of a request;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(b) For files that are archived, documents must be mailed within 30 days of receipt of a request;

(c) If a claim is lost or has been destroyed, the insurer must ~~so~~ notify the requester and the director in writing within 14 days of receiving the request for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice; and

(d) If the insurer does not possess any documents at the time the request is received:

(A) The insurer must mail any documents relating to the claim it receives to the requestor within 14 days of receipt of the documents; and

(B) The request will be considered ongoing for 90 days.

(56) Complaints of violation.

Complaints about a violation of the rules regarding release of requested claims documents must be made in writing and mailed or delivered to the division within 180 days of the request for documents, and must include a copy of the request submitted under section (3) of this rule.

(a) When notified by the director that a complaint has been filed, the insurer must mail or deliver a written response to the director within 14 days of the mailing date of the director's inquiry letter. A copy of the response, including any attachments, must be simultaneously mailed to the requester of claim documents.

(b) If the director does not receive a timely response or the insurer provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty against the insurer under OAR 436-060-0200. Assessment of a penalty does not relieve the insurer of its obligation to provide a response.

(67) Failure to provide documents.

The director may assess a civil penalty against an insurer that fails to provide documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

Statutory authority: ORS 656.726(4) and 656.745

Statutes implemented: ORS 656.360, 656.362, and 656.745.

Hist: Amended 11/28/16 as WCD Admin. Order 16-055, eff. 1/1/17

Amended 3/13/20 as WCD Admin. Order 20-054, eff. 4/1/20

Amended xx/xx/xx as WCD Admin. Order 21-xxx, eff. 1/1/22

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.

436-060-0035 Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) For the purpose of this rule:

(a) "**Primary job**" means the job at which the injury occurred, or the job where the worker was employed at the time of medical verification that the worker is unable to work because of disability caused by occupational disease;

ORDER NO. 21-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

- (b) "**Secondary job**" means any other job held by the worker in Oregon subject employment at the time of injury;
- (c) "**Temporary disability**" means wage loss replacement for the primary job;
- (d) "**Supplemental disability**" means wage loss replacement for the secondary jobs that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210; and
- (e) "**Insurer**" has the same meaning as OAR 436-060-0005~~(12)~~(13), and also includes service companies.

(2) Election to process and pay supplemental disability.

An insurer may elect to be responsible for payment and processing of supplemental disability benefits to a worker employed in more than one job at the time of injury. The insurer is not required to inform the director of its election if it elects to process and pay supplemental disability, unless the insurer's last notice to the director was that it would not process and pay supplemental disability. If the insurer informs the director of its election, the insurer must report its election to the director under OAR 436-060-0011(12).

- (a) The election must be made by the insurer, and applies to all service companies an insurer may use for processing claims.
- (b) The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election.
- (c) If the insurer has elected to process and pay supplemental disability benefits:
 - (A) The insurer must determine the worker's ongoing entitlement to supplemental disability;
 - (B) The insurer must pay the worker supplemental disability benefits simultaneously with any temporary disability benefits due;
 - (C) The insurer must maintain a record of supplemental disability benefits paid to the worker, separate from temporary disability benefits paid as a result of the job at injury; and
 - (D) The director will reimburse the insurer for supplemental disability paid under OAR 436-060-0500.
- (d) If the insurer has elected not to process and pay supplemental disability benefits:
 - (A) The director will select an assigned processing administrator who is authorized to process and pay supplemental disability benefits on behalf of the director;
 - (B) The assigned processing administrator must determine the worker's ongoing entitlement to supplemental disability and must pay the worker supplemental disability benefits due once each 14 days; and
 - (C) The insurer and assigned processing administrator must cooperate and communicate, as necessary, to coordinate benefits due.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

- (i) The assigned processing administrator must provide the insurer with any verifiable documentation of wages from a secondary job received from the worker; and
- (ii) The insurer and assigned processing administrator must retain documentation of shared information.

(3) Eligibility for supplemental disability.

A worker who was employed at one or more secondary jobs with Oregon subject employers at the time of injury or medical verification of an occupational disease may be eligible to receive supplemental disability if:

- (a) The worker provides notification of the secondary job to the insurer within 30 days of the insurer's receipt of the initial claim;
- (b) The rate of compensation for wages at the primary job under OAR 436-060-0025 is less than the maximum temporary disability rate established under ORS 656.210; and
- (c) The worker provides verifiable documentation of the wages from any secondary jobs at the time of injury or medical verification of an occupational disease within 60 days of the mailing date of the request for documentation sent under section (4) of this rule. For each secondary job, the documentation must:
 - (A) Identify the Oregon subject employer for each secondary job;
 - (B) Establish that the worker held the secondary job, in addition to the primary job, at the time of injury or medical verification of occupational disease; and
 - (C) Provide adequate information to calculate the average weekly wage under OAR 436-060-0025.

(4) Determination of eligibility.

Upon receiving notification of a worker's secondary job the insurer must determine the rate of temporary disability compensation for wages at the primary job under OAR 436-060-0025, and:

- (a) If the rate of temporary disability compensation meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits; or
- (b) If the rate of temporary disability is less than the maximum temporary disability rate, the worker may be eligible for supplemental disability benefits. If the worker may be eligible for supplemental disability benefits, the insurer must:
 - (A) Mail the worker a request for verifiable documentation of the worker's wages from any secondary jobs within five business days of notice or knowledge that the worker may be eligible for supplemental disability benefits;
 - (i) The request must inform the worker what verifiable documentation the worker must submit to the insurer or assigned processing administrator, to determine the worker's eligibility for supplemental disability;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(ii) The request must clearly state that if the insurer or assigned processing administrator does not receive the required documentation within 60 days of the mailing date of the request, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred, and the worker will be found ineligible for supplemental disability;

(B) If the insurer has elected not to process and pay supplemental disability benefits under section (2) of this rule, the insurer must also send a copy of the request to the assigned processing administrator. In addition to the requirements of this section, the request must also:

(i) Contain the name, address, email address, and telephone number of the assigned processing administrator;

(ii) Clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator; and

(C) The insurer or assigned processing administrator must determine the worker's eligibility for supplemental disability within 14 days of:

(i) Receipt of the worker's verifiable documentation; or

(ii) The end of the 60-day period in the insurer's request, if the worker does not provide verifiable documentation.

(c) Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this section will not result in a penalty under ORS 656.262(11).

(5) Notification of eligibility determination.

The insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the determination to the worker and the worker's attorney, if any, in writing. If the worker is found ineligible for supplemental disability, the letter must also advise the worker of the reason why they are not eligible, and how to appeal if the worker disagrees with the determination.

(6) Calculation of supplemental disability.

The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding the weekly averages of the worker's wages from each secondary job as calculated under OAR 436-060-0025. For the purposes of calculating and payment of supplemental disability:

(a) The total rate of supplemental disability may not exceed the difference between the maximum rate of temporary disability under ORS 656.210(1) and the rate of compensation for wages under the worker's primary job;

(b) No supplemental disability is due for jobs where the rate of compensation is based on an assumed wage;

(c) In no case may an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer;

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(d) The worker's scheduled days off for the primary job must be used to calculate and pay supplemental disability; and

(e) No three-day waiting period applies to supplemental disability benefits.

(7) Partial disability.

When a worker who is eligible to receive supplemental disability benefits has post-injury wages from either the primary job or any secondary job:

(a) The insurer or the assigned processing administrator must calculate the rate of temporary partial disability due to the worker under OAR 436-060-0030 based on the worker's wages from both the primary and secondary jobs;

(b) The insurer or the assigned processing administrator must calculate the amount of supplemental disability by subtracting the rate of partial disability due based on wages from only the primary job from the total rate of compensation due to the worker;

(c) If the worker receives post-injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due; and

(d) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(8) If temporary disability is not due from the primary job.

Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job.

(a) A nondisabling claim will not change to disabling status due to payment of supplemental disability.

(b) When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(9) Worker's responsibilities.

A worker who is eligible for supplemental disability under this rule has an ongoing responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(10) Hearings.

If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing under OAR 436-060-0008.

(a) If the worker requests a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's

ORDER NO. 21-XXX

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule.

(b) The insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

(11) Sanctions.

An insurer that elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(12) Third party recovery.

In the event of a third party recovery:

(a) Previously reimbursed supplemental disability benefits are a portion of the paying agency's lien; and

(b) Remittance on recovered benefits must be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and ORS 656.593.

Statutory authority: ORS 656.210 and 656.726(4)

Statutes implemented: ORS 656.210, 656.212, 656.325(5), 656.704, and 656.726(4)

Hist: Amended 12/14/17 as WCD Admin. Order 17-062, eff. 1/1/18

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[Amended xx/xx/xx as WCD Admin. Order 21-xxx, eff. 1/1/22](#)

See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf

436-060-0180 Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

(a) "**Compensable injury**" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

(b) "**Exposure**" means a specific incident or period during which a compensable injury may have occurred.

(c) "**Responsibility**" means liability under the law for the acceptance and processing of a compensable claim.

(2) General.

The director will designate by order which insurer must pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

(a) Which subject employer is the true employer of the worker;

(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to the worker;

**DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
Proposed CLAIMS ADMINISTRATION**

- (c) Which of two or more employers or their insurers is responsible for paying compensation for one or more on-the-job injuries or occupational diseases; or
- (d) Which of two or more employers is responsible when there is joint employment.

(3) Own motion claims.

With the consent of the board, own motion claims under ORS 656.278(1) are subject to this rule.

(4) Determination of compensability.

Upon learning of any of the issues described in section (2) of this rule, the insurer must expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable.

- (a) For the purposes of this rule, insurers identified in a potential responsibility dispute under ORS 656.307 must, upon request, share claim related medical reports and other information pertinent to the injury without charge in order to expedite claim processing.
- (b) The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute constitutes authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240.
- (c) Copies of claims documents must be mailed under the time frames established in OAR 436-060-0017~~(4)~~(5).
- (d) An insurer that shares information under this rule bears no legal liability for disclosure of the information.

(5) Notification of affected insurers.

Upon learning of any of the issues described in section (2) of this rule, the insurer must immediately notify any other affected insurers of the situation. Such notice must identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice must identify each period of exposure that the insurer believes responsible for the compensable injury by the following:

- (a) Name of employer;
- (b) Name of insurer;
- (c) Specific date of injury or period of exposure; and
- (d) Claim number, if assigned.

(6) Request for designation of a paying agent.

Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer must request designation of a paying agent from the director in writing and mail a copy of the request to the worker and the worker's attorney, if any.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

- (a) The insurer may not attach the request to, or include the request in, any form or report the insurer is required to submit under OAR 436-060-0011 or in the denial letter to the worker required by OAR 436-060-0140.
- (b) The request, or agreement to designation of a paying agent, is not an admission that the insurer is responsible for the compensable injury; it is solely an assertion that the injury is compensable against a subject Oregon employer.
- (c) The insurer's written request must contain the following information:
- (A) Identification of the compensable injuries or occupational diseases;
 - (B) That the insurer is requesting designation of a paying agent under ORS 656.307;
 - (C) That the insurer acknowledges the claim is otherwise compensable;
 - (D) That responsibility is the only issue;
 - (E) Identification of the specific claims or exposures involved by:
 - (i) Employer;
 - (ii) Insurer;
 - (iii) Date of injury or specific period of exposure; and
 - (iv) Claim number, if assigned;
 - (F) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; and
 - (G) Confirmation the worker has been advised of the actions being taken on the worker's claim.
- (d) The director will not designate a paying agent when:
- (A) It has not been determined if the injury is compensable against a subject Oregon employer;
 - (B) An insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim; or
 - (C) The 60 day appeal period of a denial expired and:
 - (i) No request for hearing had been received by the board; or
 - (ii) No request for a designation of paying agent order had been received by the director.

(7) Failure to respond to request for clarification.

When notified by the director that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer must provide written clarification to the director, the worker, the other insurers involved and other interested parties within 21 days of the mailing date of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g., failing to answer specific questions or provide requested documents), the director may assess a civil penalty under OAR 436-060-0200.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(8) Insurer responsibilities.

Insurers receiving notice from the director of a worker's request for designation of a paying agent must immediately process the request in accordance with sections (4) through (6) of this rule.

(9) Factors for designation.

Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the director will issue an order designating a paying agent under ORS 656.307. The director will designate the insurer with the lowest compensation considering the following factors:

- (a) The claim with the lowest temporary total disability rate;
- (b) If the temporary total disability rates and the rates per degree of permanent disability are the same, the earliest claim;
- (c) If there is no temporary disability or the temporary total disability rates are the same, but the rates per degree of permanent disability are different, the claim with the lowest rate per degree of permanent disability;
- (d) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement;
- (e) If one claim is under own motion jurisdiction, that claim, even if it is not the claim with the lowest temporary total disability rate; and
- (f) If more than one claim is under own motion jurisdiction, the own motion claim with the lowest temporary total disability rate.

(10) Referral to the Worker's Compensation Board.

By copy of its order, the director will refer the matter to the board to set a proceeding under ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(11) Responsibilities of designated paying agent.

The designated paying agent must process the claim as an accepted claim through claim closure under OAR 436-030-0015 unless it is relieved of the responsibility by an order of the administrative law judge or resolution through mediation or arbitration under ORS 656.307(6).

- (a) The parties to an order under this section may not settle any part of a claim under ORS 656.236 or 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers.
- (b) Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the director's prior approval.
- (c) The Consumer and Business Services Fund is not obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
WORKERS' COMPENSATION DIVISION
***Proposed* CLAIMS ADMINISTRATION**

(d) Compensation paid under the order must include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due must be for periods subsequent to periods of disability already paid by any insurer.

(12) Change in compensability or claims status.

After a paying agent is designated, if any of the insurers determine compensability may be an issue at hearing, the insurer must notify the director.

(a) Any insurer must notify the director and all parties to the order of any change in claim acceptance status after the designation of a paying agent.

(b) When the director receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the director will order termination of any further benefits due from the original order designating a paying agent.

Statutory authority: ORS 656.307, 656.726(4), and 656.745

Statutes implemented: ORS 656.307, 656.308, and 656.745

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See also the Index to Rule History: http://wcd.oregon.gov/laws/Documents/Rule_history/436_history.pdf.