REQUEST FOR REIMBURSEMENT FROM THE RETROACTIVE PROGRAM

To: Department of Consumer & Business Services
Workers' Compensation Division
Compliance Section
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405

For the period _____ through _____

FATAL BENEFITS

A.	B.	C.	D.	E.	F.
				SUBTOTAL:	**$0.00**

PERMANENT TOTAL DISABILITY

A.	B.	C.	D.	E.	F.	G.	H.
						SUBTOTAL:	**$0.00**

TEMPORARY TOTAL DISABILITY

A.	B.	C.	D.	E.	F.	G.	H.
						-	
						-	
						SUBTOTAL:	**$0.00**
					TOTAL THIS QUARTER:		**$0.00**

I certify that the payments reported have been made in the amounts indicated and have not been previously reimbursed.
Reimbursement is requested in the amount of _____ .

Mail reimbursement to insurer: _____
TPA: _____
Address: _____

Signed: _____ Print or type name: _____
Title: _____ Telephone No: ( )

440-3285 (9/06/DCBS/WCD/WEB)