WCD Workers' Compensation Division
Department of Consumer and Business Services

Employer-at-Injury Program (EAIP) Reimbursement Request Form

(See form instructions on reverse side)

(check one) ☐ **Initial request** ☐ **Correction** ☐ **Additional request** ☐ **Amended**

WCD use only

Worker information

(1) Worker name: _____
(2) SSN: _____
(3) Date of birth: _____
(4) Date of injury: _____
(5) WCD file no.: _____
(6) Address: _____
City/state: _____ ZIP: _____

(7) Insurer claim no.: _____
(8) ☐ Accepted, date: _____
☐ Denied, date: _____ ☐ Deferred
(9) ☐ Disabling ☐ Nondisabling
(10) Employer: _____
(11) Policy no.: _____
(12) WCD employer no.: _____

EAIP information

EAIP period: Start date: _____ End date: _____

Wage subsidy information

Wage subsidy period: Start date: _____ End date: _____

Reimbursement requested for _____ transitional work days.

Concurrent injuries (OAR 436-105-0530)

☐ EAIP period interrupts EAIP for claim no.: _____

☐ EAIP period interrupted by EAIP for claim no.: _____

Interruption start date: _____

Interruption end date: _____

Purchase information

(a) EAIP purchases (tuition, books and fees, tools, equipment, and clothing) **or**
(b) worksite modifications

Type (a) or (b)	Purchase date	Itemized list of purchases	Item cost

Attach a separate list in same format, if necessary. Attach the required documentation for purchases under OAR 436-105-0540(5).

Total request $

Summary

(1) Total wages paid: $ _____ **x .50 =** $ _____
(2) EAIP purchases (*complete above and attach the required documentation)*..... Total reimbursement: $ _____
(3) Worksite modification (*complete above and attach the required documentation)* Total reimbursement: $ _____
(4) Administrative cost (flat rate of $180) reimbursed on initial request only: ..... $ _____

Total reimbursement requested: $

Certifications and reimbursement information: I certify either that I am an insurer, self-insured employer, or service company or that the insurer, self-insured employer, or service company authorized me to submit this reimbursement request on their behalf. I certify that the employer and worker qualify for the Employer-at-Injury Program, and that all information cited on this form is in accordance with OAR 436-105.

Insurance company/self-insured employer: _____

Service company (if applicable): _____

Send reimbursement to this address: _____ City/state: _____ ZIP: _____

Insurer representative name (please print or type): _____ Signature or e-signature: _____

Phone: _____ Email: _____ Date: _____

Send to: Workers' Compensation Division, Performance Section, 350 Winter St. NE, P.O. Box 14480, Salem, OR 97309-0405
Or fax to 503-947-7725

Employer-at-Injury Program (EAIP) Reimbursement Request Form Instructions

Initial request: Check this box if this is the first request for reimbursement for this claim and EAIP period. (Initial requests must be a **minimum of $100**, not including the administrative cost.)

Correction: Check this box if correcting a form returned by the division for being incomplete or containing an error.

Additional request: Check this box if there was a prior approved EAIP request for this claim within the same EAIP period. (There is no administrative cost allowed on additional requests.)

Amended: Check this box if you are amending a previously processed request.

Worker information

(1) **Worker name:** Enter the worker's legal name at the time of injury.

(2) **SSN:** Enter the worker's complete Social Security number.

(3) **Date of birth:** Enter the worker's date of birth.

(4) **Date of injury:** Enter the date of injury provided by the insurer on the 801/1502/Notice of Acceptance/Denial.

(5) **WCD file no.:** Enter the file number provided by the Workers' Compensation Division. (Leave blank if unknown.)

(6) **Address:** Enter the worker's current address, including city, state, and ZIP code.

(7) **Insurer claim no.:** Enter the claim number the insurer assigned to the injured worker's claim. (If the insurer has changed a previous claim number, provide both and write "New" in front of the new claim number.)

(8) **Accepted:** If the claim is accepted, check this box and enter the date it was accepted as stated in the Notice of Acceptance.
Denied: If the claim is denied, check this box and enter the date it was denied as stated in the Notice of Denial.
Deferred: Check this box if the claim has not been accepted or denied. Reimbursement may be requested up to but not after the denial date.

(9) **Disabling:** Check this box if this claim is disabling.
Nondisabling: Check this box if this claim is nondisabling.
Note: A "disabling" or "nondisabling" status must be designated on both accepted and denied claims.

(10) **Employer:** Enter the legal name of the employer at the time of injury or aggravation.

(11) **Policy no.:** Enter the policy number provided by the insurer.

(12) **WCD employer no.:** Enter the WCD number assigned to the employer. You can look up the WCD employer number at http://www4.cbs.state.or.us/ex/wcd/employer/. If you cannot locate the number, call WCD at 503-947-7814 or email wcd.employerinfo@dcbs.oregon.gov.

EAIP information

EAIP period start date: Enter the date the worker was released to modified work.
EAIP period end date: Enter the date the claim closes or the worker is no longer eligible under OAR 436-105-0512.
Concurrent injuries: Enter the other claim number that is affected by this claim's Employer-at-Injury Program.

Wage subsidy information

Wage subsidy period start date: Enter the date the worker returned to modified work.
Wage subsidy period end date: Enter the date the worker ends transitional work.
Reimbursement requested for transitional work days: Enter the number of *transitional work days* (may not exceed 66 work days in a 24-consecutive month period).

Purchase information

Enter the details of any purchases or modifications made and attach the required documentation under OAR 436-105-0540(5): **(a)** EAIP purchase (tuition, books and fees, tools, equipment, and clothing) ***or*** **(b)** Worksite modification.

Summary

(1) Enter the total wages paid and multiply x .50.

(2) **EAIP purchases/total reimbursement:** Enter the total of (a) purchases from the itemized list, if applicable.

(3) **Worksite modification/total reimbursement:** Enter the total of (b) purchases from the itemized list, if applicable.

(4) **Administrative cost reimbursed on initial request only:** Enter the $180 administrative cost for the initial request, in accordance with OAR 436-105-0540(2).

Certifications and reimbursement information (See 436-105-0500: Insurer Participation in the EAIP.)

- **Insurance company/self-insured employer:** Enter the insurance company or self-insured employer responsible for the workers' compensation claim **at the time of injury**.
- **Service company:** Enter the service company, if applicable.
- **Send reimbursement to this address:** Enter the address where funds are to be sent.
- **Insurer representative name and signature:** Enter the name of the person completing this form and sign the form.
- **Phone number, email, and date:** Enter the representative's phone number, email address, and the date the form is mailed.

Questions

If you have **reimbursement questions,** call 503-947-7751. If you have **program questions**, call 800-445-3948 (toll-free).