



# Oregon

Theodore R. Kulongoski, Governor

Department of Consumer and Business Services  
Workers' Compensation Division  
350 Winter St. NE, Room 27  
PO Box 14480  
Salem, OR 97309-0405  
1-800-452-0288, (503) 947-7810  
TTY (503) 947-7993  
[www.wcd.oregon.gov](http://www.wcd.oregon.gov)

**BULLETIN NO. 102 (Revised)**  
**September 22, 2006**

TO: Workers' compensation insurers and self-insured employers

SUBJECT: Reimbursement from the Retroactive Program

**This bulletin provides the format for requesting reimbursement from the Retroactive Program. This bulletin replaces Bulletin 102 revised March 29, 1991.**

The Workers' Compensation Division will reimburse insurers for program benefits paid by insurers in accordance with ORS 656.506 and OAR 436-075. Insurers must submit separate requests for each company within an insurer group. Reimbursement requests must be mailed or delivered to the division within 30 days after the end of each quarter to be processed in that quarterly disbursement. Late requests will be held over and processed with the next quarterly disbursement.

Requests for reimbursement must include the data elements listed below, for each type of benefit paid. The insurer may use either the attached Form 440-3285 (Form 3285), its own equivalent form, or the self-calculating forms available on the Workers' Compensation Division's Web site (Microsoft Word 2000<sup>®</sup> or Microsoft Excel 2000<sup>®</sup> for larger volumes): [www.wcd.oregon.gov/policy/bulletins/formsbyno.html](http://www.wcd.oregon.gov/policy/bulletins/formsbyno.html). An example of a completed Form 3285 is also attached.

**Fatal**

- A. Injured worker name
- B. Date of injury
- C. Current marital and dependency status
- D. Statutory monthly payment
- E. Total months paid this quarter
- F. Amount of retroactive benefits paid

**Permanent Total Disability**

- A. Injured worker name
- B. Date of injury
- C. Weekly wage at time of injury
- D. Current marital and dependency status
- E. Statutory monthly payment
- F. Amount of Social Security offset, if applicable
- G. Total months paid this quarter
- H. Amount of retroactive benefits paid

**Temporary Total Disability**

- A. Injured worker name
- B. Date of injury
- C. Current marital and dependency status on claims prior to 7/1/71 only
- D. Weekly wage at time of injury/scheduled days off
- E. Statutory weekly payment
- F. Total weeks paid this quarter
- G. From/thru dates
- H. Amount of retroactive benefits paid

If you have any questions about this bulletin, please call the In-office Audit and Certification Unit, at (503) 947-7706.

/s/ John L. Shilts

John L. Shilts, Administrator  
Workers' Compensation Division

Distribution: WCD-ID, S0, S1, LY

Attachments: Form 440-3285, "Request for Reimbursement from the Retroactive Reserve"  
Form 440-3285, Example