Workers' Compensation Carrier Request for Information

DS1657 REV 05/25

[For CalSTRS' Official Use Only]

CALSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

If you filed a workers' compensation claim for the impairment directly related to your *Disability Benefits Application*, this *Workers' Compensation Carrier Request for Information* form must be completed by your employer's workers' compensation carrier.

Member: Complete sections 1, 2 and 3 of this form and send it directly to your workers' compensation carrier. Your carrier will complete the second page and send the requested information to CalSTRS.

Workers' Compensation Carrier: Complete sections 4 and 5 of this form. Include copies of all reports for the claim numbers listed.

Section 1: Member Information

CLIENT ID

DATE OF BIRTH (MM/DD/YYYY)

LAST NAME

FIRST NAME

MI

Section 2: Workers' Compensation Information

NAME OF WORKERS' COMPENSATION CARRIER

WORKERS' COMPENSATION CLAIM NUMBER	DATE OF INJURY	BODY PARTS
WORKERS' COMPENSATION CLAIM NUMBER	DATE OF INJURY	BODY PARTS
WORKERS' COMPENSATION CLAIM NUMBER	DATE OF INJURY	BODY PARTS

Section 3: Authorization to Release Workers' Compensation Information

The purpose of this authorization is to assist CalSTRS with determining my eligibility for receiving a CalSTRS disability benefit. I hereby authorize you to release to CalSTRS or its representatives any and all information, including photocopies of records in your possession, which CalSTRS requires solely to assist in determining my physical or mental impairment. This authorization remains valid during the entire period my application is being considered and/or I am receiving a disability benefit from CalSTRS.

MEMBER'S SIGNATURE TO AUTHORIZE RELEASE OF INFORMATION TO CALSTRS	SIGNATURE DATE (MM/DD/YYYY)

Section 4: To Be Completed By Workers' Compensation Carrier Insurance Carrier

	Claim 1	**Claim 2**	**Claim 3**
Claim Number:	_____	_____	_____
Date of Injury:	_____	_____	_____
Inability Accepted:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Condition P&S:	_____	_____	_____
Body Parts:	_____	_____	_____

_____

IF INABILITY IS NOT ACCEPTED, PLEASE PROVIDE THE REASON (INCLUDE CLAIM NUMBER).

_____

IF CONDITION IS NOT PERMANENT AND STATIONARY, WHAT IS ESTIMATED DATE? (INCLUDE CLAIM NUMBER)

CALSTRS Client ID: Or SSN:

Section 4: To Be Completed By Workers' Compensation Carrier Insurance Carrier Continued

	Claim 1	Claim 2	Claim 3
Has Settlement Occurred?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Stipulated Award:	_____%	_____%	_____%
C&R:	$_____	$_____	$_____
F&A:	_____%	_____%	_____%
Further Exams Scheduled?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Appointment Date:	_____ ☐ QME ☐ AME	_____ ☐ QME ☐ AME	_____ ☐ QME ☐ AME
Treating Physician:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Doctor's Name:	_____	_____	_____
Specialty:	_____	_____	_____

Section 5: Signature of Workers' Compensation Insurance Carrier

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

REPRESENTATIVE'S SIGNATURE	SIGNATURE DATE (MM/DD/YYYY)
PRINT NAME	PHONE NUMBER
EMAIL ADDRESS	

Mail to: CalSTRS ● P.O. Box 1527, MS43 ● Sacramento, CA 95821-0257 ● FAX 916-414-5040