Workers' Compensation Carrier Request for Information

DS1657 REV 09/23

[For CalSTRS' Official Use Only]

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

Provide either your Client ID or Social Security number.

CLIENT ID

SOCIAL SECURITY NUMBER

LAST NAME

FIRST NAME

ADDRESS (number, street, apt or suite no.)

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PHONE NUMBER

SECTION 2: WORKERS'COMPENSATION INFORMATION

NAME OF WORKERS' COMPENSATION CARRIER

SECTION 2: WORKERS' COMPENSATION INFORMATION CONTINUED

WORKERS' COMPENSATION CLAIM NUMBER	DATE OF INJURY	BODY PARTS

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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 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			
LIABILITY ACCEPTED	□ YES □ NO	□ YES □ NO	□ YES □ NO
CONDITION P&S			
BODY PARTS			

IF LIABILITY IS NOT ACCEPTED, PROVIDE REASON (INCLUDE CLAIM NUMBER)

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

	Claim 1	Claim 2	Claim 3
HAS SETTLEMENT OCCURRED?	□ YES □ NO	□ YES □ NO	□ YES □ NO
STIPULATED AWARD	%	%	%
C&R	$	$	$
F&A	%	%	%

SECTION 4: TO BE COMPLETED BY WORKERS' COMPENSATION CARRIER INSURANCE CARRIER CONTINUED

	Claim 1	Claim 2	Claim 3
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

REPRESENTATIVE'S SIGNATURE

DATE (MM/DD/YYYY)

PRINT NAME

PHONE NUMBER

EMAIL ADDRESS

Mail to: CalSTRS | P.O. Box 15275, MS 43 | Sacramento, CA 95851-0275 | FAX 916-414-5040