

Workers' Compensation Carrier Request for Information

(DS 1657 rev. 1/11)

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

NAME (LAST, FIRST, INITIAL)

SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)

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

Date Signed (MM/DD/YYYY)



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**Workers' Compensation Carrier
Request for Information** continued

Name _____ SSN _____

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

	Claim 1	Claim 2	Claim 3
Claim Number	_____	_____	_____
Date of Injury	_____	_____	_____
Liability Accepted	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stipulated Award	_____ %	_____ %	_____ %
C&R	\$ _____	\$ _____	\$ _____
F&A	_____ %	_____ %	_____ %

	Claim 1	Claim 2	Claim 3
Further Exams Scheduled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appointment Date:	_____	_____	_____
	<input type="checkbox"/> QME <input type="checkbox"/> AME	<input type="checkbox"/> QME <input type="checkbox"/> AME	<input type="checkbox"/> QME <input type="checkbox"/> AME
Treating Physician:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Doctor's Name:	_____	_____	_____
Specialty:	_____	_____	_____

Section 5: Signature of Workers' Compensation Insurance Carrier

Representative's Signature:  _____

Date: _____

Print Name: _____

Phone Number: _____

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