Paid Leave Oregon

EQUIVALENT PLAN DISPUTE RESOLUTION FORM

Complete this form if you would like to request dispute resolution assistance through Paid Leave Oregon for a dispute between yourself and your equivalent plan employer or administrator.

Please note that you must follow the appeal process of your equivalent plan before you can request a dispute resolution as described in OAR 471-070-2220.

EMPLOYEE INFORMATION		
Legal first name:		
Legal last name(s):		
Preferred name, if different:		
Social Security Number (SSN): _____ or Individual Taxpayer Identification Number (ITIN):		
If you do not have a Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN), contact Paid Leave Oregon for assistance at 833-854-0166.		
Date of birth (MM/DD/YYYY): / /		
Driver's license/state identification number:		
Issuing state:		
EMPLOYEE CONTACT INFORMATION		
Phone country:		
Phone number: ( ) -		
Email address:		
Language preference:		
EMPLOYEE PHYSICAL ADDRESS		
Street line 1:		
Street line 2:		
Unit type:	Unit number:	City:
State:	Zip:	
Attention:		
EMPLOYEE MAILING ADDRESS *(If different from physical address)*		
Street line 1:		
Street line 2:		
Unit type:	Unit number:	City:
State:	Zip:	
Attention:		

Employee name:	SSN/ITIN:
EQUIVALENT PLAN EMPLOYER INFORMATION	
Employer business name:	
Business Identification Number (BIN): _____ or Federal Identification Number (FEIN):	
EMPLOYER CONTACT INFORMATION	
Employer contact name:	
Employer contact phone number: ( ) -	
Employer contact email address:	
EQUIVALENT PLAN APPEAL INFORMATION	
Please include a copy of your employer's or administrator's appeal decision and any documents related to the dispute or the appeal decision with this form.	
Equivalent plan appeal number:	
Estimated start date of leave:	
EQUIVALENT PLAN DISPUTE INFORMATION	
Please describe the reason for the dispute. In your response, please explain how the dispute relates to your coverage or benefits under your employer's or administrator's equivalent plan.	

Employee name:	SSN/ITIN:

CERTIFICATION

☐ I certify under penalty of law that the information I have provided is true and correct to the best of my knowledge and belief.

☐ I understand that Paid Leave Oregon will inform my employer about my dispute request.

Signature _____ Date _____

☐ I am a claimant designated representative.

Claimant designated representative (Print name) _____

Claimant designated representative signature _____ Date _____

Provide all required information and documents. Missing information or documents can cause a delay in processing your dispute request.

Please return this form and the required documentation to:

Attn: Paid Leave Oregon
Oregon Employment Department
875 Union St NE
Salem, OR 97311

Need help?
The Oregon Employment Department (OED) is an equal opportunity agency. OED provides free help so you can use our services. Some examples are sign language and spoken-language interpreters, written materials in other languages, large print, audio, and other formats. To get help, please call 833-854-0166 (toll free). TTY users call 711. You can also send an email to paidleave@oregon.gov.