Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be upsetting and stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Call our reporting center

877-836-1555

Preregistration Required

To set up and gain access to our online system

Call **860-683-7078**

Once registered, report a claim online

www.Netclaim.net

So that you're best prepared to report the claim, please see the reverse side for information we may request from you.

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

GREAT AMERICAN INSURANCE GROUP

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

Alternative Markets
Claim Reporting Center:

877-836-1555

Call Preparation Guide For
Workers' Compensation Claims

Gathering complete and accurate information is the first step toward a fair and timely resolution of any claim.

When you contact the Alternative Markets Claim Reporting Center to report a claim, you will be asked a series of questions needed to complete the First Report of Injury. The items listed on the reverse side will assist with your preparation.

Once the data is collected by the Claim Reporting Center:

- Your claim will be assigned to an Alternative Markets Claim professional who will contact you to acknowledge the claim and initiate the process.
- You and your employee will receive an acknowledgment letter with the claim number and information needed to contact us directly.
- The Claim Reporting Center provides you with a copy of the First Report of Injury.
- This report will be sent directly to the state either by mail or electronic submission, based on your state's requirements.

We support employers' return to work plans, and make every effort to assist you with yours. **Please report a claim as soon as you are aware of it to 877-836-1555.**
We are here 24/7!

GREAT AMERICAN INSURANCE GROUP
Alternative Markets

Alternative Markets Claim Reporting Center:

877-836-1555

Call Preparation Guide For Workers' Compensation Claims

POLICY NUMBER: _____

ACCIDENT INFORMATION:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

EMPLOYEE INFORMATION:

- Name, physical home address, county, and home phone
- Date of birth, social security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

MEDICAL PROVIDER INFORMATION:

- Name of clinic/doctor's office where employee treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

REQUIRED WORKERS' COMPENSATION COVERAGE

The law requires that each person working on this site or providing services related to this construction project must be covered by workers' compensation insurance. This includes persons providing, hauling, or delivering equipment or materials, or providing labor or transportation or other services related to the project, regardless of the identity of their employer or status as an employee.

Call the Division of Workers' Compensation at 512-804-4345 to receive information on the legal requirement for coverage, to verify whether your employer has provided the required coverage, or to report an employer's failure to provide coverage.

TO THE EMPLOYER/CONTRACTOR:

Pursuant to Workers' Compensation Rule 110.110(d)(7), a contractor engaged in a building or construction project for a government entity is required to post a notice on each project site informing all persons providing services on the project that they are required to be covered by workers' compensation insurance. The notice required by this does not satisfy other posting requirements imposed by the Texas Workers' Compensation Act or other Workers' Compensation Rules. This notice must:

(1) be posted in English, Spanish and any other language common to the employer's employee population;
(2) be displayed on each project site;
(3) state how a person may verify current coverage and report failure to provide coverage;
(4) be printed with a title in at least 30-point bold type and text in at least 19-point normal type; and
(5) contain the exact words as prescribed in Rule 110.110 (d)(7)

The notice on the reverse side meets the above requirements. Failure to post the notice as required by this rule is a violation of the Act and Workers' Compensation Rules. The violator may be subject to administrative penalties.

COBERTURA REQUERIDA DE COMPENSACIÓN PARA TRABAJADORES

La ley requiere que cada persona que trabaja en este lugar o que proporciona servicios relacionados con este proyecto de construcción debe estar cubierta por un seguro de compensación para trabajadores. Esto incluye a personas que proporcionan, transportan, o entregan equipo o materiales, o que proporcionan mano de obra, u otros servicios relacionados con este proyecto, sin importar la identidad del empleador o el estado como empleado.

Comuníquese con la División de Compensación para Trabajadores al teléfono 512-804-4345 para recibir información referente a los requerimientos legales de cobertura, para verificar si su empleador ha proporcionado la cobertura requerida, o para reportar a un empleador que no proporciona cobertura.

AL EMPLEADOR / CONTRATISTA:

Según el Reglamento de Compensación para Trabajadores 110.110 (d)(7), requiere que un contratista que está involucrado en el proyecto de construcción de un edificio de entidad gubernamental muestre este aviso en cada lugar donde se lleva a cabo el proyecto para así informar a todas las personas que proporcionan servicios en el proyecto que se les debe proporcionar un seguro de compensación para trabajadores. El aviso presentado aquí no satisface otros aviso de requerimientos impuestos por la Ley de Compensación para Trabajadores de Texas u otros Reglamentos de Compensación para Trabajadores. Este aviso debe:

(1) ser mostrado en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador;
(2) ser mostrado en cada área de trabajo en el proyecto;
(3) explicar como una persona puede verificar la cobertura actual del empleador y como reportar si el empleador no ofrece cobertura;
(4) ser impreso con un título en por lo menos tamaño 30, con letra negrita de punto, y el texto en por lo menos tamaño 19 en punto tipo normal; y
(5) contener las palabras exactas como se ha señalado en el Reglamento 110.110 (d)(7).

El aviso que se muestra al reverso de esta página cumple con los requisitos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la ley y Reglamentos de Compensación para Trabajadores. El infractor puede estar sujeto a penalidades administrativas.

COVERED EMPLOYER

Texas Workers' Compensation Rule 110.101(e)(1) requires employers who are covered by workers' compensation through a commercial insurance company to advise their employees that they do have workers' compensation insurance coverage and to advise their employees of the Texas Department of Insurance, Division of Workers' Compensation's toll free number to obtain additional information about their workers' compensation rights.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(1).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ has workers' compensation insurance coverage from [name of commercial insurance company] _____ in the event of work-related injury or occupational disease. This coverage is effective from [effective date of workers' compensation insurance policy] _____. Any injuries or occupational diseases which occur on or after that date will be handled by [name of commercial insurance company] _____ _____. An employee or a person acting on the employee's behalf, must notify the employer of an injury or occupational disease not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an occupational disease, unless the Texas Department of Insurance, Division of Workers' Compensation (Division) determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will answer any questions you may have about workers' compensation and process any requests for dispute resolution of a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031. The Office of Injured Employee Counsel (OIEC) also provides free assistance to injured employees and will explain your rights and responsibilities under the Workers' Compensation Act. You can obtain OIEC's assistance by contacting an OIEC customer service representative in your local Division field office or by calling 1-866-EZE-OIEC (1-866-393-6432).

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

WAGE INFORMATION INSTRUCTIONS

Employee Name: Social Security #: Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits.**

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty not to exceed $500.00 for an initial offense and not to exceed $10,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at www.tdi.state.tx.us

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number:	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ As of today's date, the employee is not back at work. **OR**
☐ The employee returned to work on _____ and is working:
☐ without restriction. **OR**
☐ with restrictions and is earning wages of $_____ per week/month (circle one).

NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at www.tdi.state.tx.us.

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

DWC FORM-6
Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
The **EMPLOYER** means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.	If you (the **INJURED WORKER)** are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.
The EMPLOYER must file this form: • **For** a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • **During** the time the injured worker is entitled to temporary income benefits (TIBs); and • **Until** the injured worker: ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer.	If you are employed by a new employer after the injury; and • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are *not* receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.

This report must be filed in the following situations within the timeframes indicated:
- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:
- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with: • The insurance carrier, and • The injured worker. This report is considered filed when personally delivered or postmarked. **Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed $500.**	**This form is to be filed** by first class mail or personal delivery with: • The insurance carrier. This report is considered filed when personally delivered or postmarked. **If you return to work** for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted. **Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.**

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: www.tdi.state.tx.us

CLAIM # _____
Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	

5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
If so, identify contact person and phone # _____ _____

6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date _____ no ☐

7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐

8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date _____ no ☐

9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	

17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
If yes, the date of the 8th day (mm/dd/yyyy) _____

18. Date of most recent RTW _____
☐ Full duty, full pay
☐ Limited duty, full pay
☐ Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
date of resignation _____ date of termination _____ date of death _____
19a. Reason for resignation/termination _____
19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐

20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week
Indicated hours are:
☐ Increase from pre-injury
☐ Same as pre-injury
☐ Decrease from pre-injury

21. Weekly/hourly earnings for the pay period of _____ to _____ : $ _____ weekly or $ _____
Indicated wages are:
☐ Increase from pre-injury wage
☐ Same a pre-injury wage
☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

_____ _____
Signature and Title of person completing this form Date

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months _____ Years _____

33. Length of Service in Occupation Months _____ Years _____

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $_____Weekly

37. Full Work Week is: _____ Hours _____ Days

38. Last Paycheck was: $_____ for ___ Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed $500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 -5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

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Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name

29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months _____ Years _____

33. Length of Service in Occupation Months _____ Years _____

34. Employee Payroll Classification Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $_____Weekly

37. Full Work Week is: _____ Hours _____ Days

38. Last Paycheck was: $_____ for ___ Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10/05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

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"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
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Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

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Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☐

3. Social Security Number - -

4. Home Phone ( )

5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*

19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

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28. Supervisor's Name

29. Date Reported (m-d-y) - -

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32. Length of Service in Current Position Months _____ Years _____

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34. Employee Payroll Classification Code

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37. Full Work Week is: _____ Hours _____ Days

38. Last Paycheck was: $_____ for ___ Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form

41. Name of Business

42. Business Mailing Address and Telephone Number
Street or P.O. Box Telephone ( )

City State Zip Code

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

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Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
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DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM -1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]

EMPLEADORES DE EMPLEADOS DEL SERVICIO DE AMBULANCIA, PARAMÉDICOS, BOMBEROS, POLICÍAS Y OFICIALES DEL DEPARTAMENTO DE CORRECCIONALES.

Según el Reglamento 110.108 del Departamento de Seguros de Texas, División de Compensación para Trabajadores, los empleadores de empleados del servicio de ambulancia, paramédicos, bomberos, policías, u oficiales del departamento de correccionales deben poner a la vista avisos para informar a los empleados sobre los requisitos que contiene el Código de Seguridad y Salud el cual podría afectar en el proceso de calificación para recibir beneficios de compensación para trabajadores después de haber sido expuesto a una enfermedad reportada. Este aviso debe:

1. ser puesto a la vista en la oficina de personal, si es que la hay;
2. ser puesto a la vista en el área de trabajo de tal manera que los empleados vean este aviso regularmente;
3. ser impreso con un título en tamaño 15, letra negrita de punto, y el texto por lo menos en tamaño 14 punto tipo normal;
4. contener el texto que ha sido dispuesto en el Reglamento 110.108(d);
5. ser puesto a la vista en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador.

El aviso que se muestra al reverso de esta página cumple con los requisitos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la Ley de Compensación para Trabajadores de Texas y reglamentos de la División y el infractor puede estar sujeto a recibir multas administrativas.

El costo del examen de una enfermedad reportada deberá ser pagado por la compañía de seguros de compensación para trabajadores del empleador.

AGENCIAS ESTATALES:

Según el Reglamento del Departamento de Seguros de Texas, División de Compensación para Trabajadores 110.108 cada agencia estatal debe poner a la vista avisos donde se informa a los empleados sobre los requisitos, los cuales pueden afectar el proceso de calificación para recibir beneficios después de haber sido expuesto al virus de inmunodeficiencia humana (VIH).
Este aviso debe:

1. ser puesto a la vista en la oficina de personal de la agencia;
2. ser puesto a la vista en el área de trabajo de tal manera que los empleados vean este aviso regularmente;
3. ser impreso con un título en tamaño 15, letra negrita de punto, y el texto por lo menos en tamaño 14 punto tipo normal.
4. contener un texto como ha sido dispuesto en el Reglamento 110.108(d);
5. ser puesto a la vista en inglés, español, o en inglés y cualquier otro idioma común para la población de los trabajadores del empleador.

El aviso que se muestra en el reverso de esta página cumple con los requisitos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la Ley de Compensación para Trabajadores de Texas y reglamentos de la División y el infractor puede estar sujeto a recibir multas administrativas.

El costo del examen de una enfermedad reportada deberá ser pagado por la compañía de seguros de compensación para trabajadores del empleador.

NO MOSTRAR ESTE LADO

DEPARTAMENTO DE SEGUROS DE TEXAS,
DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES
AVISO REFERENTE A CIERTAS ENFERMEDADES CONTAGIOSAS RELACIONADAS CON EL TRABAJO Y LA ELEGIBILIDAD PARA OBTENER BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES

PARA: Policías, Bomberos, Empleados del Servicio de Ambulancia Paramédicos, y Oficiales del Departamento de Correccionales -

PARA PODER CALIFICAR PARA RECIBIR BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES, EL EMPLEADO QUE RECLAMA QUE POSIBLEMENTE FUE EXPUESTO A UNA ENFERMEDAD QUE DEBE SER REPORTADA, INCLUYENDO INFECCIÓN DEL VIRUS DEL VIH, DEBERÁ SER EXAMINADO A NO MÁS TARDAR DEL 10º DÍA DESPUÉS DE QUE HAYA SIDO EXPUESTO Y DEBERÁ PROPORCIONAR AL EMPLEADOR DOCUMENTACIÓN DEL EXAMEN Y UNA COPIA NOTARIADA CON LA FECHA Y CIRCUNSTANCIAS DE LA CAUSA POR LA CUAL FUE EXPUESTO. EL RESULTADO DEL EXAMEN DEBE INDICAR LA AUSENCIA DE LA ENFERMEDAD. NO ES REQUERIDO QUE EL EMPLEADO PAGUE POR EL EXAMEN.

Las enfermedades reportadas son todas las enfermedades contagiosas y condiciones de salud que requieren ser reportadas a la Comisión de Salud y Servicios Humanos de Texas (H&HSC, por sus siglas en inglés). El criterio para estar expuesto y el protocolo del examen debe cumplir los requisitos del H&HSC.

PARA: Todos los Empleados Estatales

PARA PODER CALIFICAR PARA BENEFICIOS DE COMPENSACIÓN PARA TRABAJADORES, EL EMPLEADO ESTATAL QUE RECLAMA QUE POSIBLEMENTE HA SIDO EXPUESTO AL VIRUS DE INMUNODEFICIENCIA HUMANA (VIH) Y QUE ESTÁ RELACIONADO CON EN TRABAJO, DEBERÁ HACERSE UNA PRUEBA DEL VIH DENTRO DE 10 DÍAS DESPUÉS DE QUE FUE EXPUESTO Y DEBERÁ PROPORCIONAR AL EMPLEADOR DOCUMENTACIÓN DEL EXAMEN Y UNA DECLARACIÓN POR ESCRITO CON LA FECHA Y CIRCUNSTANCIA DE LA CAUSA POR LA CUAL FUE EXPUESTO. EL RESULTADO DE LA PRUEBA DEBE INDICAR LA AUSENCIA DE INFECCIÓN DEL VIH. NO ES REQUERIDO QUE EL EMPLEADO PAGUE POR EL EXAMEN.

PARA MAYOR INFORMACIÓN: HABLE CON SU EMPLEADOR O LLAME AL DEPARTAMENTO DE SEGUROS DE TEXAS, DIVISIÓN DE COMPENSACIÓN PARA TRABAJADORES AL 1-800-372- 7713. TAMBIÉN, COMUNÍQUESE CON LA COMISIÓN DE SALUD Y SERVICIOS HUMANOS PARA ASEGURARSE QUE LOS REQUISITOS DE LAS REGLAS DE SALUD Y SEGURIDAD DEL H&HSC HAN SIDO CUMPLIDOS.

TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
NOTICE REGARDING CERTAIN WORK-RELATED COMMUNICABLE DISEASES AND ELIGIBILITY FOR WORKERS' COMPENSATION BENEFITS

TO: Law Enforcement Officers, Fire Fighters, Emergency Medical Service Employees, Paramedics, and Correctional Officers -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, AN EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO A REPORTABLE DISEASE, INCLUDING HIV INFECTION, MUST BE TESTED FOR THE DISEASE NOT LATER THAN THE 10TH DAY AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A SWORN AFFIDAVIT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF THE DISEASE. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

Reportable diseases are those communicable diseases and health conditions required to be reported to the Texas Department of Health. Exposure criteria and testing protocol must conform to Texas Department of Health requirements.

TO: All State Employees -

IN ORDER TO QUALIFY FOR WORKERS' COMPENSATION BENEFITS, A STATE EMPLOYEE WHO CLAIMS A POSSIBLE WORK-RELATED EXPOSURE TO HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, MUST BE TESTED FOR HIV WITHIN 10 DAYS AFTER THE EXPOSURE AND MUST PROVIDE THEIR EMPLOYER WITH DOCUMENTATION OF THE TEST AND A WRITTEN STATEMENT OF THE DATE AND CIRCUMSTANCES OF THE EXPOSURE. THE TEST RESULT MUST INDICATE THE ABSENCE OF HIV INFECTION. THE EMPLOYEE IS NOT REQUIRED TO PAY FOR THE TEST.

FOR ADDITIONAL INFORMATION: TALK TO YOUR EMPLOYER OR CALL THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION AT 1-800-372-7713. ALSO, CONTACT THE TEXAS DEPARTMENT OF HEALTH (TDH) TO ENSURE FULL COMPLIANCE WITH THE HEALTH AND SAFETY CODE AND TDH RULES.

PREPAYMENT ACCOUN T #:

CLAIM #
Carrier's Claim #

CARRIER'S REQUEST FOR SEASONAL EMPLOYEE WAGE INFORMATION FROM TEXAS EMPLOYMENT COMMISSION RECORDS

A $15.00 fee must be paid for this request for seasonal employee wage information from the Texas Employment Commission. No action will be taken on the request without payment. Send the request with payment to: Employee/Employer Field Services, Workers' Compensation Information Services Center, MS-602, Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

1. Employee's Name (Last, First M.I.) **and** Telephone Number ( )	2. Social Security Number	3. Date of Injury
4. Mailing Address (Street or P.O. Box)	5. Employer's Business Name	
City State ZIP Code	6. Insurance Carrier's Name	

On _____ the insurance carrier shown above filed notice with the injured seasonal employee of its
DATE
intention to request the Texas Department of Insurance, Division of Workers' Compensation's approval to adjust the employee's average weekly wage and temporary income benefit payment because of a seasonal change in the employee's wages. The seasonal employee did not provide wage information to the carrier within two (2) weeks from the date of notice according to a thorough search of the carrier's records.

The insurance carrier requests the Texas Department of Insurance, Division of Workers' Compensation to contact Texas Employment Commission for the seasonal employee's wage history for the most recent five (5) quarters available.

ADJUSTER CERTIFICATION

I certify the wage information requested will be used solely to determine whether an injured seasonal employee's average weekly wage and temporary income benefit payment should be adjusted.

Adjuster's Name (PRINTED)	Adjuster's Signature
Adjuster's Business Mailing Address (Street or P. O. Box)	City State ZIP Code

DIVISION USE ONLY

Date Information Requested from TEC	Date Information Provided to Carrier's Designated Austin Representative

2. **Usted tiene la responsabilidad de saber si pertenece a una Red de Servicios Médicos de Compensación para Trabajadores (red) (Workers' Compensation Health Care Network -network).**
   Si no sabe si pertenece a una red de servicios médicos, pregúntele al empleador para el cual usted trabajaba al momento en que ocurrió su lesión. Si pertenece a una red, es su responsabilidad seguir los reglamentos de dicha red. Si usted encuentra algo que no entiende, pregunte a su empleador o llame a OIEC. Si desea presentar una queja sobre una red, llame a la Línea de Ayuda al Consumidor de TDI (TDI's Consumer Help Line, por su nombre en inglés) al 1-800-252-3439 o presente su queja en línea en www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **Si usted trabajó para una subdivisión política (p. ej. la ciudad, el condado o el distrito escolar) al momento en que sucedió su lesión, es su responsabilidad averiguar cómo recibir tratamiento médico.**
   Su empleador debe poder proporcionar la información que usted necesita para determinar cuáles son los proveedores de servicios médicos que pueden atender su lesión relacionada con el trabajo.

4. **Usted tiene la responsabilidad de informar a su médico cómo es que usted se lesionó y determinar si la lesión está relacionada con el trabajo.**

5. **Usted tiene la responsabilidad de completar y enviar a DWC el Formulario DWC-041, Reclamo del Empleado para Compensación por una Lesión Relacionada con el Trabajo o Enfermedad Ocupacional.**
   Usted cuenta con un año para enviar el formulario después de haberse lesionado o después de haberse enterado que su enfermedad podría estar relacionada con su trabajo. Complete y envíe el Formulario DWC-041 aun si ya está recibiendo beneficios. Usted puede perder su derecho a recibir beneficios si no envía a tiempo el formulario completo a DWC. Para obtener una copia del Formulario DWC-041 comuníquese con DWC o con OIEC.

6. **Usted tiene la responsabilidad de proporcionar su dirección actual, número de teléfono e información sobre su empleador a DWC y a la aseguradora. Usted puede comunicarse con DWC al 1-800-252-7031.**

7. **Usted tiene la responsabilidad de informarle a DWC y a la aseguradora cada vez que haya un cambio en el estado de su empleo o su salario.**
   (Algunos ejemplos de cambios incluyen: si deja de trabajar a causa de su lesión; si usted regresa a trabajar; o si recibe una oferta de trabajo).

8. **Los beneficiarios que son elegibles o las personas que buscan obtener beneficios por causa de muerte o beneficios de gastos para el entierro, tienen la responsabilidad de completar y enviar a DWC el Formulario DWC-042, Reclamación del Beneficiario para Obtener Beneficios por Causa de Muerte dentro de un año, a partir de la fecha en que el empleado falleció.**

9. **Usted tiene prohibido hacer reclamaciones o demandas injustificadas o fraudulentas.**

4. **Usted puede tener derecho a recibir atención médica para atender su lesión o enfermedad que sucedió en el área de trabajo, durante todo el tiempo que sea médicamente necesario y relacionado con la lesión que sucedió en el área de trabajo.**
   Usted puede tener derecho a recibir un reembolso por los gastos incurridos después de viajar para asistir a una cita médica o a un examen médico requerido (required medical examination, por su nombre en inglés), si el viaje cumple con las condiciones de calificación.

5. **Usted puede tener derecho a recibir beneficios de ingresos por su lesión relacionada con el trabajo.**
   Existen varios tipos de beneficios de ingresos, así como requisitos de elegibilidad. La información sobre los tipos de beneficios de ingresos que pueden estar disponibles, y los requisitos de elegibilidad pueden ser encontrados en www.tdi.texas.gov o consultando al personal de OIEC.

6. **Usted puede tener derecho a una resolución de disputas con respecto a sus beneficios de ingresos y beneficios médicos.**
   Usted puede solicitar una Resolución de Disputas Médicas (Medical Dispute Resolution, por su nombre en inglés) si está en desacuerdo con la aseguradora sobre los beneficios médicos. Usted puede solicitar una Resolución de Disputas por Indemnización (Ingresos) (Indemnity (Income) Dispute Resolution, por su nombre en inglés), si está en desacuerdo con la aseguradora sobre los beneficios de ingresos. La ley establece que sus procedimientos de resolución de disputas sean llevados a cabo dentro de 75 millas del domicilio suyo.

7. **Usted tiene derecho a escoger a su médico de tratamiento.**
   Si usted pertenece a una red de servicios médicos de compensación para trabajadores (Workers' Compensation Health Care Network), (red), debe escoger a su médico de la lista de médicos de tratamiento de la red. Usted puede cambiar a su médico de tratamiento una sola vez sin la necesidad de obtener la aprobación de la red. Si no pertenece a una red, usted puede inicialmente escoger a cualquier médico que esté dispuesto a atender su lesión de compensación para trabajadores; sin embargo, si usted no pertenece a una red, el cambio de su médico de tratamiento debe ser pre-aprobado por DWC. Si es empleado de una subdivisión política, tal como la ciudad, el condado, o el distrito escolar, usted deberá seguir los reglamentos de dicha subdivisión política para escoger a un médico de tratamiento. Es importante seguir todos los reglamentos en el sistema de compensación para trabajadores. **Si usted no sigue estos reglamentos, podría ser considerado responsable por el pago de las facturas médicas.** El personal de OIEC puede ayudarle a entender estos reglamentos.

8. **Usted tiene derecho a que la información sobre su reclamación de compensación para trabajadores se mantenga confidencial.**
   En la mayoría de los casos, el contenido del expediente de su reclamación no puede ser obtenido por otras personas. Algunos participantes tienen derecho a conocer el contenido del expediente de su reclamación, tal como su empleador o la aseguradora de su empleador. También, un empleador que esté considerando contratarle a usted puede obtener información limitada por parte de DWC sobre su reclamación.

Sus Responsabilidades Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene la responsabilidad de informar a su empleador si se ha lesionado en el trabajo mientras desempeñaba sus deberes de trabajo. Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o del día en que usted se dio cuenta que su lesión o enfermedad podría estar relacionada con su trabajo.**

Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores de Texas

En Texas, usted como empleado lesionado tiene derecho a recibir ayuda gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel -OIEC, por su nombre y siglas en inglés). Esta ayuda se ofrece en las oficinas locales en todo el estado. Las oficinas locales también proporcionan otros servicios del sistema de compensación para trabajadores por parte del Departamento de Seguros de Texas (Texas Department of Insurance -TDI, por su nombre y siglas en inglés). TDI, es la agencia estatal que regula y administra el sistema de compensación para trabajadores mediante la División de Compensación para Trabajadores (Division of Workers' Compensation –DWC, por su nombre y siglas en inglés).

Muchos de los servicios que son proporcionados por parte de OIEC y de DWC pueden ser llevados a cabo por teléfono. Usted puede comunicarse con OIEC llamando al teléfono gratuito 1-866-EZE-OIEC (1-866-393-6432). Visite el sitio Web de OIEC en www.oiec.texas.gov, para obtener información adicional, incluyendo la ubicación de las oficinas. Usted puede comunicarse con DWC llamando al teléfono gratuito 1-800-252-7031. La información de DWC se encuentra disponible en la página de Internet: www.tdi.texas.gov.

Sus Derechos Dentro del Sistema de Compensación para Trabajadores de Texas:

1. **Usted tiene derecho a contratar a un abogado para asistirle con su reclamación de compensación para trabajadores.**
   Para obtener asistencia para encontrar a un abogado, llame al servicio de recomendación de abogados de la Barra de Abogados del Estado de Texas (State Bar of Texas, por su nombre en inglés) al 1-877-983-9227 o visite www.texasbar.com. La información sobre la recomendación de abogados también puede encontrarse en la página de Internet de OIEC en www.oiec.texas.gov.

2. **Usted tiene derecho a recibir asistencia por parte de OIEC si no cuenta con un abogado.**
   Los Representantes de Servicio al Cliente de OIEC, así como los Ombudsman están disponibles para responder a sus preguntas y proporcionarle asistencia con su reclamación de compensación para trabajadores ya sea llamando a OIEC o visitando una de las oficinas de OIEC. **Usted debe firmar una autorización por escrito antes que un empleado de OIEC pueda tener acceso a la información sobre su reclamación.** Llame o visite una oficina de OIEC para completar la autorización por escrito. Los Representantes de Servicio al Cliente de OIEC y los Ombudsman han sido entrenados en el campo de compensación para trabajadores y pueden ayudarle a programar un procedimiento de resolución de disputas, relacionado con su reclamación de compensación para trabajadores. Un ombudsman también puede asistirle en una Conferencia para Revisión de Beneficios (Benefit Review Conference –BRC, por su nombre y siglas en inglés), en una Audiencia para Disputar Beneficios (Contested Case Hearing –CCH, por su nombre y siglas en inglés), y en una apelación. Sin embargo, un Ombudsman no puede tomar decisiones por usted, ni dar opiniones por usted o proporcionar asesoramiento legal.

3. **Con ciertas excepciones, usted tiene derecho a recibir beneficios médicos y beneficios de ingresos sin importar quién tuvo la culpa de su lesión. Sus beneficiarios podían tener derecho a recibir beneficios por causa de muerte y beneficios de gastos para el entierro.**
   La información sobre las excepciones puede encontrarse en www.tdi.texas.gov o consultando al personal de OIEC.

If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however, changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. **If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4001 fax • www.tdi.texas.gov

YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code Section 406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:

(1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;

(2) shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;

(3) shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;

(4) shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3), (e)(4) for appropriate language); and

(5) if the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of the employer] _____ _____tiene cobertura de seguros de compensación para trabajadores con [name of the commercial insurance company] _____ para protegerle en caso de una lesión o enfermedad ocupacional relacionada con el trabajo. Esta cobertura está vigente desde [effective date of workers' compensation insurance policy] _____. Cualquier lesión o enfermedad ocupacional que ocurra en o después de esta fecha será manejada por [name of commercial insurance company]_____ _____. Un empleado o una persona que actúe en nombre del empleado, debe notificar al empleador sobre una lesión o una enfermedad ocupacional a no más tardar de treinta (30) días, a partir de la fecha en que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad ocupacional, al menos que el Departamento de Seguros de Texas, División de Compensación para Trabajadores (Texas Department of Insurance, Division of Workers' Compensation – TDI-DWC, por su nombre y siglas en inglés) (División) determine que existió una buena causa para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO: La División proporciona información gratuita sobre cómo presentar una reclamación de compensación para trabajadores. El personal de la División contestará cualquier pregunta que usted pueda tener sobre la compensación para trabajadores y procesará cualquier solicitud de resolución de disputas relacionada con una reclamación. Usted puede obtener este tipo de asistencia comunicándose con su oficina local de la División o llamando al teléfono 1-800-252-7031. La Oficina de Asesoría Pública para el Empleado Lesionado (Office of Injured Employee Counsel – OIEC, por su nombre y siglas en inglés) también ofrece asistencia gratuita a los empleados lesionados y ellos le explicarán cuáles son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores. Usted puede obtener la asistencia de OIEC comunicándose con un representante de servicio al cliente de OIEC en su oficina local de la División o llamando al 1-866-EZE-OIEC (1-866-393-6432).

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADOR CON COBERTURA

El Reglamento 110.101 (e)(1) de Compensación para Trabajadores de Texas requiere que los empleadores que cuentan con una cobertura de compensación para trabajadores mediante una compañía de seguros comercial notifiquen a sus empleados que ellos cuentan con una cobertura de seguro de compensación para trabajadores e informen a sus empleados sobre el número de la línea telefónica gratuita del Departamento de Seguros de Texas, División de Compensación para Trabajadores para obtener información adicional sobre sus derechos de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO