



Managing General Agency

**Workers' Compensation
CLAIMS KIT**

ANCHOR CLAIMS MANAGEMENT, INC. TEXAS CLAIMS KIT INTRODUCTION PAGE

Anchor Claims Management, Inc. will provide the claims services on behalf of

for all claims under this policy. We are providing this Claims Kit to assist you in correctly reporting claims to us and meeting your responsibilities as an employer in your state. All claims or correspondence regarding claims should be directed to:

ANCHOR CLAIMS MANAGEMENT, INC.
P. O. BOX 819045
DALLAS, TX 75381-9045
PHONE: 800-275-3193 OR 972-247-2621
FAX: 800-275-3194 OR 972-247-2622

CONTENTS OF CLAIMS KIT

REPORTING GUIDELINE INFORMATION

Anchor Claims Management, Inc., Claims Reporting Guidelines
State of Texas Reporting Guidelines
Supervisor's Accident Investigation Report

POSTINGS NOTICES:

Notice To Employees Concerning Workers Compensation Insurance In Texas
English Version (TWCC Notice 6) *
Spanish Version (TWCC Notice 6S)*

CLAIM REPORTING FORMS:

Employer's First Report Of Injury Or Illness	TWCC-1
Employer's Report For Reimbursement of Voluntary Payments	TWCC-2
Employer's Wage Statement	TWCC-3
Employer's Contest of Compensability	TWCC-4
Supplemental Report of Injury	TWCC-6

PUBLICATIONS:

Information for Employers
Employee Rights and Responsibilities
List of Ombudsman Offices

Please remove the English and Spanish language Posting Notices from the Claims Kit and display them in your place of business, where your employees will be able to see them, as required by the State of Texas. If you have multiple locations, copy these forms as needed and post copies in each of your locations.

* One copy of each of the listed Claims Reporting Forms is included in the Claims Kit. Please copy them as needed to maintain at least one unused copy of each form for use during the policy term.

GUIDELINES FOR CLAIMS REPORTING

When an accident (or alleged accident) occurs:

1. See that the injured employee receives prompt medical attention.
2. Obtain pertinent information about the claim.
 - * To assist you with this, we suggest that you have the supervisor fill out a Supervisor's Accident Investigation Report.
3. Immediately submit an injury report online at:

https://www.combinedgroup.com/acm/first_report

Alternatively, you may complete the enclosed form and mail or fax to:

ANCHOR CLAIMS MANAGEMENT
P.O. BOX 819045
DALLAS, TX
75381-9045

FAX 1-800-275-3194

4. Accidents resulting in death or severe injury should be reported immediately by telephone. Call toll free 1-800-275-3193.
5. After we have received the accident report, you will be contacted to assist us in the investigation of the claim.
6. Following the investigation, we will commence benefits if it is a compensable claim.
7. Once the claim has been set up, you will receive regular phone calls giving you an updated status on the claim. We ask that you contact us immediately if you obtain any new information regarding the claim.
8. On lost-time cases, call us the day the employee returns to work.
9. If you should have any questions concerning a claim, do not hesitate to call us at 1-800-275-3193 between 8:00 A.M. and 5:00 P.M. Monday through Friday.

GUIDELINES AND SUGGESTIONS FOR IMPLEMENTING EMPLOYER'S RESPONSIBILITY UNDER THE TEXAS WORKERS' COMPENSATION ACT

I. Employer's Responsibility for Prompt Claim Reporting - Employers Reporting of Occupational Injury or Disease

- A. Submit Employer's First Report of Injury or Illness Form TWCC (1). This must be typed or printed in ink. Anchor Claims Management, Inc. (ACM) will forward a copy to the Texas Workers' Compensation Commission (TWCC).

This must be submitted to the TWCC and ACM no later than eight days after the employee is absent from work for one day.

- B. In case of death, heart attack, spine fracture or other serious injuries, call ACM Claims Department and submit an Employer's First Report of Injury to ACM immediately.

If at all possible we encourage the use of our FAX machine to expedite the arrival. Our FAX number is 1-800-275-3194.

- C. Keep a copy of the Employer's First Report of Injury for your records and give a copy to the injured employee. The employer must also provide the insured employee with a copy of the Employee's Rights and Responsibilities.
- D. Upon receipt of the First Report of Injury, ACM has seven days to pay or deny weekly benefits. If weekly benefits are initiated, we then have 60 days to file a denial should additional information become available to us.

*It is very important that you take note of these deadlines as the Texas Workers' Compensation Commission will be levying fines if these deadlines are not met. The fines can be levied against both the employer and the insurance carrier.

Your participation in the investigation process of the claim becomes imperative. This will allow us to make the proper decision within time guidelines.

- E. There is a seven day waiting period before compensation is paid. This period will be paid after the employee has been off work for 28 days.
- F. The injured employee's compensation rate will be figured on 75% of his/her wages if they make less than \$8.50 an hour. If the wages were over \$8.50 per hour, the rate would be calculated at 70%. The average weekly wage will be based on the 13 weeks preceding the accident.

*The employer has 30 days to complete a wage statement if compensation benefits have been paid.

G. Return to work status:

1. If the employee has not lost any time or has returned to work, notify ACM by the following:
 - a. Complete box 26 on the Employer's First Report of Injury.
 - b. If the employee has returned to work after the employer has sent the first report, call ACM at 1-800-275-3193 and advise us of the return to work date. Also at that time an Employer's Supplemental Report should be completed and forwarded to the Dallas Claims Office.

II. Employer's Responsibility for Medical Treatment

- A. Medical Control is given to the employee, but if an injured employee seeks medical treatment he/she should be encouraged to be examined and treated by a doctor that you are familiar with. Although we do not have Medical Control in Texas, you should try to make arrangements with a clinic/doctor for initial consultation. The employer can control many small claims in this manner.
- B. ACM may request a medical examination from a doctor of our choice. This is only allowable once every six months.
- C. The employee is required to get a second opinion prior to any non-emergency spinal surgery.
- D. The injured employee has lifetime reasonable and necessary medical treatment as it relates to his original injury. Therefore we are not able to close out the future medical treatment.

III. Employer's Responsibility to Return Employees to Work - Modified Job Program

The employer should try to provide a job for the injured employee in the form of light duty if released to do so by the attending physician.

- A. Light duty jobs save your claim dollars since the employer can terminate compensation by notifying the employee that light duty is available during the healing of the injured employee.
- B. We recommend that the employer notify the doctor and ACM that light duty is available.
- C. The light duty offer should be conveyed by certified mail to the employee with a carbon copy sent to ACM.

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT
work related or on-the-job incident/injury

Send this form to your company's main office, Manager, Risk Manager, or designee within 24 hours.

Employee Name _____
Date of birth: _____ Sex _____ Wage _____ SSN _____
Employee Address _____ Phone No. (work) _____ Phone No. (home) _____
Department/Shift: _____ Occupation: _____ How Long on Job? _____

Date of work injury _____ Exact time of injury _____ Where did this happen?,
incl. street address or department/location the employee was in at the time. _____
List witnesses, addresses and phone numbers, including any persons that may have
knowledge of the injury or incident, if known.
Name _____ Address _____ Ph.# _____
Name _____ Address _____ Ph.# _____
Name _____ Address _____ Ph.# _____
Did you take the employee to the doctor? Yes _____ No _____
Did the employee go to a doctor on own? Yes _____ No _____
Did the employee lose any work time due to the alleged injury i.e. unable to report to work for the
next regular shift? Yes _____ No _____
List attending physician and or Hospital, if known.
Doctor Name _____ Address _____ Ph.# _____
Hospital Name _____ Address _____ Ph.# _____
How long is the employee expected to be off work, if any?
Has the employee returned to work? Yes _____ No _____ (as of date of this report)

A. What Happened? *Describe what took place or what caused you to make this investigation.*

B. Why Did It Happen? *Get all the facts by studying the job and the situation involved. Question by use of WHY, WHAT, WHERE, WHEN, WHO, AND HOW. (Do not use words, like "careless", "not alert" state why such acts or inattention were involved in the first place)*

C. What Should Be Done to prevent repeat of similar incident? (To be completed by the injured employees immediate supervisor ... Manager should suggest any additional action).
Number each action. Determine which items need additional attention (people, equipment, material). Do not use words/phrases like "cautioned" "Told to be careful".

Continued on back

D. What Have You Done Thus Far? *Use the same action numbers as above. Take recommended action, depending on your authority. Follow-up: Was action effective? Insert work order numbers.*

_____ Date _____

_____ Date _____

E. How Will This Improve Operations?

Name of the injured employees immediate supervisor _____ Ph.# _____

Investigated By: _____ Title _____ Date _____ Ph.# _____

Employee signature _____

Name of company nurse, if any _____ Ph.# _____

Reviewing Dept. or Area Manager: _____ Date _____

Date this report was completed _____

Date this report was forwarded to the company manager or front office _____

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: _____ has workers' compensation insurance coverage from _____ to protect you in the event of work-related injury or illness. This coverage is effective from _____. Any injuries or illnesses which occur on or after that date will be handled by _____. An employee or a person acting on the employee's behalf must notify the employer of an injury or illness 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 illness, unless the Commission determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Commission provides free information about how to file a workers' compensation claim. Commission staff will explain your rights and responsibilities under the Workers' Compensation Act and assist in resolving disputes about a claim. You can obtain this assistance by contacting your local Commission field office or by calling our toll-free number at 1-800-252-7031. **SAFETY HOTLINE:** The Commission has established 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 of Workers' Health and Safety at 1-800-452-9595.

AVISO SOBRE COMPENSACION PARA TRABAJADORES EN TEJAS

COBERTURA: _____ tiene aseguranza para compensar al trabajador con _____ para protegerlo en el caso de una lesion o enfermedad relacionada con su trabajo. Esta aseguranza esta vigente desde _____ Cualquier lesion o enfermedad que ocurra en o a partir de esa fecha sera manejada por la _____. El trabajador o la persona que lo representa debe notificar al patron cuando ocurra una lesion o enfermedad antes de treinta (30) dias despues de que ocurra la lesion o dentro de treinta (30) dias de la fecha en que el empleado se entero o deberia estar enterado de la enfermedad, salvo que la Comision determine que existia un buen motive para no haber notificado al patron dentro del tiempo senalado. Su patron esta obligado a proporcionarle informacion sobre la aseguranza cuando lo contrate para trabajar y asi mismo debe de informarle cuando obtenga o deje de tener seguro de compensacion para el trabajador.

ASISTENCIA AL EMPLEADO: La Comision le proporcionara informacion gratuita sobre como someter un reclamo de compensacion para el trabajador. El personal de la Comision le explicara cuales son sus derechos y responsabilidades bajo la Ley de Compensacion para el Trabajador y le asistira para resolver cualquier controversia que surja al hacer su reclamo. Usted predo obtener esta ayuda comunicandose con la oficina local de la Comision o llamando al numero 1-800-252-7031.

LINEA PARA REPORTAR CONDICIONES INSEGURAS: La Comision ha establecido una linea telefonica gratuita las 24 horas del dia, para reportar condiciones inseguras en el lugar de trabajo que pudiera violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los patrones suspendan, despidan o descrimined al empleado o unloeada porque el o ella, de buena fe, reporta una alegada violacion ocupacional de salud o segurriad. Comuniquese con Seccion de Salud y Seguridad Laboral al numero 1-800-452-9595.

EMPLOYER:

Per Rule 110.101(e)(1) of the Texas Workers' Compensation Commission, TWCC Notice 6 is required to advise your employees that you have workers' compensation insurance through a commercial insurance company and to advise your employees of the Texas Workers' Compensation Commission's toll free number to obtain additional information about their workers' compensation rights.

As of January 1, 1994, 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 30 point bold type, subject in at least 20 point bold type, and text in at least 19 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 Commission rules. The violator may be subject to administrative penalties.

**Form TWCC-1
(Employer's First Report of Injury or Illness)**

The **employer** is required to file an **Employer's First Report of Injury or Illness** [Form TWCC-1 (Rev. 7/03)] 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 Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

[Texas Workers' Compensation Commission Rule 120.2]



INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (TWCC-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 (Form TWCC - 1 (Rev. 7-03)) 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 Workers' Compensation Commission, unless the Commission 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 Workers' Compensation Commission, unless the Commission specifically requests a direct filing.** The Commission's Health and Safety Division 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 Commission 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 Commission 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.



Send the specific copies to your
Worker's Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Workers Compensation Commission, unless
the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
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 <input type="checkbox"/> NO <input type="checkbox"/>			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box			
City	State	Zip Code	County
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependant 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 <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began	
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 <input type="checkbox"/> NO <input type="checkbox"/>		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)
- -	YES NO		- -

30. Date of Hire (m-d-y)	31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 ()		43. Business Location (if different from mailing address) Number and Street	
City	State	Zip Code	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.
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48. Worker's Compensation Insurance Company	49. Policy Number
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50. Did you request accident prevention services in the past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>
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51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____



TWCC# _____
Carrier's Claim # _____

EMPLOYER'S REPORT FOR REIMBURSEMENT OF VOLUNTARY PAYMENT

1. Employer's Name			13. Employee's Name (Last, First, M.I.)		
2. Employer's Mailing Address (Street or P.O. Box)			14. Employee's Mailing address (Street or P.O. Box)		
City	State	Zip Code	City	State	Zip Code
3. Federal Tax I.D. No.			15. Employee's Social Security Number		
4. Date of Injury	5. Date of this Notice		16. Name of Insurance Carrier		
6. Date Lost Time Began	7. Date of Initial Payment		17. Address of Insurance Carrier (Street or P.O. Box)		
8. Amount of Payment \$	9. Number of Weeks Paid		City	State	Zip Code
10. From	11. To		18. Address of Insurance Carrier Claims Office (Street or P.O. Box)		
12. This Payment: <input type="checkbox"/> Initiates Compensation <input type="checkbox"/> Supplements Injured Employee's Income <input type="checkbox"/> Covers Medical Expenses Incurred			City	State	Zip Code
			19. Insurance Carrier Representative		

The employer should notify Texas Workers' Compensation commission and the insurance carrier within 14 days after the date of initial payment. An employer who fails to timely file the report of injury or occupational disease as required by Art. 8308-5.05, of the Texas Workers' Compensation Act waives the right to reimbursement of any voluntary payments and may be assessed an administrative penalty, not to exceed \$500.00. If there is a dispute concerning reimbursement of any employer's payments of compensation or medical benefits, the employer may file a subclaim in accordance with Art. 8308-5.08 of the Texas Workers' Compensation Act.

The insurance carrier should reimburse the employer within 30 days after receiving the request and should notify the Texas Workers' Compensation Commission within 10 days of payment of the amount and date of the reimbursement.



**Form TWCC-2
(Employer's Report for Reimbursement of Voluntary Payment)**

The employer is required to file an **Employer's Report for Reimbursement of Voluntary Payment** [Interim Form TWCC-2 (1/91)] with the TWCC and the insurance carrier. The employer waives the right to reimbursement if it fails to notify the Commission by filing Form TWCC-1 (Employer's First Report of Injury or Illness), or did not do so in a timely manner.

The **Employer's Report for Reimbursement of Voluntary Payment** enables an employer who voluntarily begins payment to an injured worker to recoup from the insurance carrier once a determination of compensability has been made. The insurance carrier, once the claim is found to be compensable, should reimburse the employer within 30 days after receiving the request. Initiation of payment to the worker in no way implies admission of compensability, and the worker must be notified that any payments made by the employer will later be deducted from compensation paid by the insurance carrier. Employers who voluntarily begin payment to an injured worker may not recover from the insured if the claim is determined not compensable.

This form will be printed as a 3-part form with the original to the carrier, the second copy to TWCC and the third copy for employer's record.

The report is considered filed when personally delivered or postmarked. Send TWCC's copy to the **field office handling the claim**.

[Art. 8308-4.06. Certain Employer Payments Reimbursable; Art. 8308-5.05. Employer Report of Injury; Administrative Violation; Art. 8308-5.08. Subclaims, Texas Workers' Compensation Act]



Sent to workers' compensation carrier:

(name and fax number of carrier)



TWCC # _____

CARRIER'S CLAIM # _____

Initial Amended

EMPLOYER'S WAGE STATEMENT

The Texas Workers' Compensation Act and Commission 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 Commission 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 Commission.

(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 Commission within seven days of receiving a request from the Commission (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 TWCC rules can be found at www.twcc.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:
<input type="checkbox"/> As of today's date, the employee is not back at work. OR <input type="checkbox"/> The employee returned to work on _____ and is working: <input type="checkbox"/> without restriction. OR <input type="checkbox"/> with restrictions and is earning wages of \$_____ per week/month (circle one).	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.
NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (TWCC-6) to report changes in Work Status and Post-Injury Earnings.	Signature: _____ Date: _____

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

<input type="checkbox"/> 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.	<input type="checkbox"/> 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.	<input type="checkbox"/> Minor: employee less than 18 years of age and not emancipated by marriage or judicial action who is not an apprentice, trainee or student.
<input type="checkbox"/> 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.	<input type="checkbox"/> 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.	<input type="checkbox"/> Student: employee enrolled in a course of study in high school, college or other institute of higher education or technical training.
	<input type="checkbox"/> Apprentice: employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.	<input type="checkbox"/> Trainee: employee undergoing systematic instruction and practice in some art, trade or professional with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for: <input type="checkbox"/> The Injured Employee OR <input type="checkbox"/> A Similar Employee (NOTE - If requested by the Commission, 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.
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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 Commission at (800) 252-7031. You can also read rule 122.5 at www.twcc.state.tx.us.



Continued on next page →

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																		



**Interim Form TWCC-4
(Employer's Contest of Compensability)**

An **employer** desiring to contest the compensability of a claim that the insurance carrier has accepted may file an **Employer's Contest of Compensability** [Interim Form TWCC-4 (1/91)] with the Texas Workers' Compensation Commission (TWCC).

The employer may contest compensability of a claim after presenting the grounds for non-compensability to the carrier and giving the carrier the opportunity to contest compensability. The employer may file the Interim Form TWCC-4 no later than 50 days after the date the insurer received written notice of the injury.

This will be printed as a single page form. The form is considered filed when personally delivered or postmarked. Send to the **TWCC field office handling the claim.**

[Art. 8308, Sec. 5.10. Employer Bill of Rights, Texas Workers' Compensation Act]





TWCC # _____
 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 <input type="checkbox"/> no <input type="checkbox"/>			
If so, identify contact person and phone # _____			
6. Has the insurance carrier provided RTW coordination services within the past 12 months?		yes <input type="checkbox"/>	DATE _____ no <input type="checkbox"/>
7. Has the employer requested RTW training from TWCC or the insurance carrier?		yes <input type="checkbox"/>	no <input type="checkbox"/>
8. Has the insurance carrier provided accident prevention services in the past 12 months?		yes <input type="checkbox"/>	DATE _____ no <input type="checkbox"/>
9. Has the employer requested accident prevention services from the insurance carrier?		yes <input type="checkbox"/>	no <input type="checkbox"/>

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

10. <input type="checkbox"/> a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
<input type="checkbox"/> b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
<input type="checkbox"/> c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
<input type="checkbox"/> 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 (cummulative) of lost time or reduced wages as a result of the injury ? yes <input type="checkbox"/> no <input type="checkbox"/>			
If yes, the date of the 8th day (mm/dd/yyyy) _____			
18. Date of most recent RTW _____		19. Has the injured worker resigned, been terminated, or died? yes <input type="checkbox"/> no <input type="checkbox"/>	
<input type="checkbox"/> Full duty, full pay		date of resignation _____ date of termination _____ date of death _____	
<input type="checkbox"/> Limited duty, full pay		19a. Reason for resignation/termination	
<input type="checkbox"/> Limited duty, reduced pay		_____	
		19b. Was the injured worker on limited duty when terminated? yes <input type="checkbox"/> no <input type="checkbox"/>	
20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week		21. Weekly/hourly earnings for the pay period of _____ to _____ : \$ _____ weekly or \$ _____ hourly	
Indicated hours are:		Indicated wages are:	
<input type="checkbox"/> Increase from pre-injury		<input type="checkbox"/> Increase from pre-injury wage	
<input type="checkbox"/> Same as pre-injury		<input type="checkbox"/> Same as pre-injury wage	
<input type="checkbox"/> Decrease from pre-injury		<input type="checkbox"/> 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



TWCC-6
Supplemental Report of Injury

TWCC 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 TWCC-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
<p>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:</p> <ul style="list-style-type: none"> • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. <p>Include TWCC and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.</p>	<p>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:</p> <ul style="list-style-type: none"> • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. <p>This form may be used to do so. Include TWCC and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.</p>
<p>The EMPLOYER must file this form:</p> <ul style="list-style-type: none"> • For a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a TWCC-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: <ul style="list-style-type: none"> ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer. 	<p>If you are employed by a new employer after the injury; and</p> <ul style="list-style-type: none"> • 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 <i>not</i> receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.
<p>This report must be filed in the following situations within the timeframes indicated:</p> <ul style="list-style-type: none"> • 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. <p>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:</p> <ul style="list-style-type: none"> • 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. 	
<p>This form is to be filed by first class mail or personal delivery with:</p> <ul style="list-style-type: none"> • The insurance carrier, and • The injured worker. <p>This report is considered filed when personally delivered or postmarked.</p> <p>Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.</p>	<p>This form is to be filed by first class mail or personal delivery with:</p> <ul style="list-style-type: none"> • The insurance carrier. <p>This report is considered filed when personally delivered or postmarked.</p> <p>If you return to work for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted.</p> <p>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.</p>

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 TWCC website at: www.twcc.state.tx.us

TEXAS WORKERS' COMPENSATION COMMISSION

Information for employers

RIGHTS RESPONSIBILITIES

*Your rights and
responsibilities in the
Texas workers'
compensation system*

The Texas Workers' Compensation Commission

Central Office:
Southfield Building
400 South IH-35
Austin, Texas 78704-7491
512-448-7900

Field Offices:

The Texas Workers' Compensation Commission has field offices throughout the state. To learn the location of the field office nearest you, call 1-800-252-7031.

What is workers' compensation?

Workers' compensation pays medical bills and replaces some of an employee's lost wages if the employee is injured at work or has a work-related disease or illness.

Participation in the state's workers' compensation system is voluntary. Texas employers may choose whether or not to maintain workers' compensation insurance. Employers who choose to have insurance may

- purchase insurance policies from private insurance companies or
- self-insure, if they meet the requirements of the Texas Workers' Compensation Act and are certified by the Texas Workers' Compensation Commission. Self-insured employers have the same rights and responsibilities as employers who buy policies from private insurance companies.

An injured worker may not sue an employer who has workers' compensation insurance or who is certified to self-insure. (A beneficiary may sue an insured employer if the employer's intentional action, intentional omission of action, or gross negligence led to a worker's death). If you have workers' compensation insurance or are self-insured, your injured employees receive the benefits provided by the Texas Workers' Compensation Act. Benefits are paid by your insurance company, or by you if you are self-insured.

An injured worker may sue an uninsured employer. If you do not have workers' compensation insurance, you must pay any payments ordered by a court, and the amount is not limited to the benefits provided by the Act.

This brochure describes your rights and responsibilities in the Texas workers' compensation system if you have workers' compensation insurance or are certified to self-insure.

Employer rights

The Texas Workers' Compensation Act guarantees you the following rights:

- You have the right to contest the compensability of a claim if your insurance carrier accepts liability. Contesting the compensability of a claim means you can argue in dispute resolution proceedings and in court that the employee's injury did not occur or that the injury or illness was not job related.
- You have the right, if you've asked your insurance carrier in writing, to have your carrier tell you of any dispute resolution or court proceeding related to an employee's claim or any proposal to settle the claim.
- You have the right to attend any dispute resolution proceeding related to an employee's claim.
- You have the right to present relevant evidence about disputed issues at dispute resolution proceedings.
- You have the right to report suspected workers' compensation fraud to the Commission or to your insurance carrier.
- You have the right to contest the failure of your insurance carrier to provide the accident prevention services required by the Texas Workers' Compensation Act.

Reimbursement of voluntary payments. You may voluntarily begin benefit payments to an injured worker or supplement a worker's benefits if the worker requests or agrees to the supplement in writing. The amount of benefits and supplements may not exceed the worker's net wage before the injury.

You will be reimbursed for supplemental payments only if the worker receives impairment income benefits. To be reimbursed, you must send form *TWCC-2, Employer's Report for Reimbursement of Voluntary Payment*, to your insurance carrier and the Commission. Send the form within 14 days of the date you make the first payment to the worker.

If you do not notify your carrier of the injury on time, you will not be reimbursed for voluntary payments. Voluntary payments do not affect the worker's eligibility for benefits or the carrier's obligation to pay them.

Payment of medical bills. You may pay an injured worker's medical bills if the worker's health care provider agrees to it. Paying medical bills does not affect the worker's eligibility for other benefits or affect your filing or reporting requirements.

Accident prevention services. Your insurance carrier must provide free accident prevention services to you. These services include surveys, safety consultations and recommendations, safety training assistance, analysis of accident causes, and industrial health and hygiene services.

Employer responsibilities

Reporting injuries

You must tell your insurance carrier about each

- work-related injury that causes an employee to miss more than one day of work
- occupational illness that you know about, even if the employee has not missed any work
- work-related fatality.

You may report injuries by mail, fax, phone, or by electronic transmission. Keep a record of the date you reported the injury to your carrier.

Notify your carrier within eight days of the date

- an employee misses more than one day of work because of a work-related injury, or
- you learn that an employee has a work-related disease or illness, or
- an employee dies because of a work-related injury or illness.

You must send a copy of the report of injury to the worker at the same time you report the injury to your carrier. The copy sent to the worker must include a statement explaining the worker's rights and responsibilities. The statement must be in wording specified by the Commission.

Your insurance carrier may send a copy of the report of injury and the statement of rights and responsibilities to the injured worker for you. However, you have the ultimate responsibility to ensure that the worker receives them.

If you do not send a copy of the report and the statement to the worker, or if you do not ensure that the worker receives them, you could be fined up to \$500 per occurrence.

Other reporting responsibilities

Employer's Wage Statement. You must report an injured worker's wages and other compensation to your insurance carrier. Send form *TWCC-3, Employer's Wage Statement*, to your carrier within 30 days of the date income benefits begin to accrue. Send a copy of the form to the worker. Do not send a copy to the Commission unless you are asked.

Supplemental Report of Injury. You must report any changes in an injured worker's pay or employment to your carrier.

Send form *TWCC-6, Supplemental Report of Injury*, to your carrier within

- 10 days of the end of a pay period in which an injured worker's pay changes, and
- 10 days of the date an injured worker resigns or is terminated, and
- three days of the date an injured worker returns to work, and
- three days of the date an injury causes a worker to miss additional work after returning to work.

Send a copy of the form to the worker.

If you do not send the required forms, or if you do not send them on time, you could be fined up to \$500 per occurrence.

Record-keeping responsibilities

You must keep a record of work-related injuries, illnesses, and fatalities. Keep records for at least five years from the last day of the year in which the injury or fatality occurred, or for the period of time required by the Occupational Safety and Health Administration, whichever is longer.

If you do not keep these records, you could be fined up to \$500.

Notice responsibilities

You must post notices in your workplace telling your employees that

- you have workers' compensation insurance and telling them the name of your workers' compensation insurance company
- the Commission has staff to explain their rights and responsibilities and to help resolve disputes about their claims
- the Commission has a 24-hour, toll-free hotline to report suspected safety violations in the workplace.

Posted notices must be in the wording and format adopted by the Commission.

If you do not post these notices, you could be fined up to \$1,000.

Notice to new employees. You must give new employees a written notice that includes the information in the posted notices. The written notice must also tell new employees that they have the right to choose not to be covered by your workers' compensation policy. Employees have five days from the date they begin employment to tell you if they do not want to be covered by your policy. The written notice to new employees must be in the wording adopted by the Commission.

NEED COPIES OF NOTICES?

For copies of notices, call 512-440-3618,
or write the Publications Department at
MS-72, 4000 South IH-35,
Austin, TX 78704-7491.

If you do not provide this notice to new employees, you could be fined up to \$500 per occurrence.

Notice of change in coverage. You must give all your employees written notice if you cancel your workers' compensation policy or if your policy is canceled by your carrier. The notice must be given to your employees within 15 days of the date you cancel your policy or are notified that your carrier intends to cancel your policy.

If you do not provide this notice to your employees, you could be fined up to \$500 per occurrence.

Other responsibilities

Drug policy, if required. If you have 15 or more employees, you must have a policy to eliminate drug abuse in your workplace. You must give a copy of the policy to each employee.

For a free copy of the Commission's *Drug-Free Workplace Resource Guide*, which includes information on developing a drug-free workplace policy, call 512-440-3868, or write the Commission's Health and Safety Resource Center at MS-25,4000 South IH-35, Austin, Texas, 78704-7491.

Accident prevention plan, if required. If you are identified by the Commission as an extra-hazardous employer or identified by the Texas Workers' Compensation Insurance Fund to participate in an injury prevention program, you must adopt an accident prevention plan developed by an approved consultant.

The consultant may be from the Commission or your insurance carrier, or may be a Commission-approved provider. The initial consultation must occur within 30 days of the date you receive notice that you have been identified to participate in an accident prevention program.

If you do not adopt an accident prevention plan and were required to do so, or if you do not adopt a plan on time, you could be fined up to \$5,000 per day of noncompliance.

NEED MORE INFORMATION OR HELP?
For more information or help, call the
Texas Workers' Compensation Commission field office
nearest you, or call 512-440-3789.

Administrative and criminal violations

Fraud

You could be fined up to \$5,000 and prosecuted for criminal fraud if you knowingly or intentionally commit an act to deny workers' compensation benefits to someone who is legally entitled to receive benefits. You could also be liable for past payments and interest.

Chargebacks

You may not charge your workers' compensation premiums back to your employees, either directly or indirectly.

If you charge premiums back to employees, you could be fined up to \$1,000 per violation. Your employees may also recover damages in court.

Misrepresentation of payroll

You could be fined up to \$5,000 per occurrence if you intentionally misrepresent your payroll or provide false information to get lower insurance premiums. You could also be held liable for missed premiums.

Discrimination against claimants

Texas law prohibits you from discharging or discriminating against an employee because the employee in good faith filed a workers' compensation claim, hired an attorney, or requested or testified in a workers' compensation proceeding. *An employee may sue you in court if you fire or discriminate against the employee for any of those reasons.*

NOTE: This booklet is for general information purposes only. It is not a substitute for the Texas Workers' Compensation Act or the administrative rules of the Texas Workers' Compensation Commission. For detailed information about your rights and responsibilities in the Texas workers' compensation system, please refer to the Texas Workers' Compensation Act (Texas Labor Code, Title 5, Subtitle A) and to the rules of the Texas Workers' Compensation Commission.

Need more information?

Call the field office nearest your or call

512-440-3789

- for more information about the Texas workers' compensation system
- for information about an employee's claim or for help resolving a dispute about a claim.

For copies of the Texas Workers' Compensation Act, Commission rules, forms, or brochures (a fee may be charged for some items), call

512-440-3618

For copies of the Commission's *Drug-Free Workplace Resource Guide* and other workplace health and safety materials, call the Health and Safety Resource Center at

512-440-3868

For information on free workplace safety consultations for small employers, call the Commission's Occupational Safety and Health Consultation (OSHCON) Program office at

512-440-3854



Employee Rights and Responsibilities under the Texas Workers' Compensation System

This information describes your rights and responsibilities under the Texas workers' compensation system. For more information or for assistance, please call the Texas Workers' Compensation Commission field office handling your claim, or call 1-800-252-7031.

Your rights under the Texas workers' compensation system

You may have the right to receive benefits

You may receive benefits regardless of who caused or helped cause your injury. You may not receive benefits if your injury occurred while you were intoxicated, you injured yourself intentionally or while unlawfully attempting to injure someone else, you were injured by another person for personal reasons, you were injured while voluntarily participating in an off-work activity, you were injured by an act of God, or your injury occurred during horseplay.

- ◀ ***You have the right to receive the medical care reasonable and necessary to treat your work-related injury or illness for the rest of your life***

You have the right to the initial choice of doctor:

You may not change doctors except with the approval of the Commission. You do not need to get approval to go to a different doctor for emergency treatment, if you or your doctor moves, or if your doctor is unable to continue treating you.

- ***You have the right to hire an attorney to help you get benefits or to help you resolve disputes***
- Ⓜ ***You have the right to receive assistance from appropriate, qualified Commission staff and, in the event of a dispute resolution proceeding from a Commission ombudsman free of charge. To request assistance, contact the field office handling your claim, or call 1-800-252-7031.***

You have the right to receive information and assistance regarding your claim. Commission staff will explain your rights and responsibilities under the Texas Workers' Compensation Act. Additionally, you have the right to be assisted by a Commission ombudsman in informal dispute resolutions and in administrative proceedings if you are not represented. However, an ombudsman cannot serve as a legal representative or attorney for you.

- ***You have the right to confidentiality.***

Only people who need to know—such as your doctor, your employer, or your employer's insurance carrier—may see information in the Commission's files. A prospective employer may get limited information from the Commission about your claims. If you wish someone who is assisting you to have access to your file, you must provide written approval for them to do so.

Your responsibilities under the Texas workers' compensation system

You have the responsibility to tell your employer about your injury or illness

You must tell your employer *within 30 days* of the date you were injured, or *within 30 days* of the date you first knew your illness might be work-related. You, or someone helping you, may either talk with or write your employer or any supervisor where you work.

If you do not tell your employer within 30 days, you could lose your right to get benefits.

- ◀ ***You have the responsibility to fill out a claim form and send it to the Commission***

You must send a completed claim form, called a TWCC-41, to the Commission *within one year* of the date you were injured, or *within one year* of the date you first knew your illness might be work-related. Send the completed claim form to the Commission even if you are already getting benefits.

If you do not send the form within one year, you could lose your right to get benefits. For a copy of the form, call the field office handling your claim, or call 1-800-252-7031.

You have the responsibility to tell the Commission and the insurance carrier any time your income changes

If you are *not* getting benefits and you have changed employers since your injury, tell the Commission if your injury causes you to miss work or lose income. Call 1-800-252-7031.

If you *are* getting benefits and you have changed employers since your injury, tell the Commission and the insurance carrier paying your benefits if your income changes. Tell the Commission and the insurance carrier regardless of whether your income went up or down. If you have stopped working since your injury, tell the Commission and the insurance carrier if you start working again or if you have a job offer.

- ***You have the responsibility to tell your doctor how you were injured and if you believe it may be work-related***

If possible, tell the doctor before the doctor treats you.

- Ⓜ ***You have the responsibility to tell the Commission and the insurance carrier how to contact you***

You should contact the Commission and the insurance carrier if your home address, work address, or phone number changes, so the Commission and the insurance carrier will be able to contact you when necessary.

Employers You must provide this information to the injured worker at the same time you report the injury to your insurance carrier. If your insurance carrier has agreed to provide this information to the worker for you, you still have the ultimate responsibility to ensure that the worker receives it. This information must be provided in English and Spanish or in English and the language common to the worker. This information may be reproduced or photocopied as necessary but may not be edited or altered in any way. (TWCC Rule 120.2)

Derechos y Responsabilidades para el Trabajador bajo el Sistema Tejano de Compensación para Trabajadores

Esta información describe sus derechos y sus responsabilidades en el sistema de compensación para trabajadores de Tejas. Para mayor información o ayuda, por favor llame a la oficina local de la Comisión Tejana de Compensación para Trabajadores que maneja su reclamo o llame al 1-800-252-7031.

Sus derechos en el sistema Tejano de compensación para trabajadores

Usted puede tener derecho a recibir beneficios

Usted puede recibir beneficios a pesar de que alguien le causó o le ayudó a causar su lesión. Puede ser que no reciba beneficios si su lesión ocurrió mientras usted estaba intoxicado, si se lesionó intencionalmente o mientras estaba tratando de lastimar a otra persona ilegalmente, o si fue lastimado por otra persona por razones personales, si se lastimó mientras estaba participando voluntariamente en una actividad fuera del trabajo y después de horas de trabajo, si fue lastimado por un acto de Dios, o si su lesión ocurrió mientras estaba pagando.

« ***Usted tiene el derecho de recibir tratamiento médico que sea razonable y necesario para tratar su lesión o enfermedad relacionada con su trabajo por el resto de su vida.***

Usted tiene el derecho de escoger a su propio médico inicialmente

Usted no puede cambiar de médico, excepto con la aprobación de la Comisión. Usted no tiene que obtener aprobación para ir a un médico diferente en casos de tratamiento de emergencia, o si usted o su médico se mudan o si su médico no está disponible para continuar con su tratamiento.

— ***Usted tiene el derecho de contratar a un abogado para que le ayude a obtener beneficios o para que le ayude a resolver disputas.***

Ⓡ ***Usted tiene el derecho de recibir asistencia gratuita del personal apropiado y calificado de la Comisión. En caso de que ocurra un procedimiento administrativo, tiene el derecho de recibir asistencia gratuita de un ombudsman para resolver disputas. Para pedir ayuda, comuníquese con la oficina local que está manejando su reclamo o llame al 1-800-252-7031.***

Usted tiene el derecho de recibir información y asistencia relacionado con su reclamo. Personal de la Comisión le explicará sus derechos y responsabilidades bajo la Ley Tejana de Compensación para Trabajadores. Adicionalmente, usted tiene el derecho de recibir asistencia de un ombudsman de la Comisión en resolución de disputas informales y en procedimientos administrativos si no tiene representación legal. Sin embargo, un ombudsman no puede servirle como su representante legal o su abogado.

— ***Usted tiene el derecho a su confidencialidad***

Solo personas que necesiten información acerca de su reclamo—como su médico, su patrón cuando se lesionó, o la compañía de seguros de ese patrón—puede ver la información en el archivo de la Comisión. Un futuro o posible patrón puede obtener información limitada de la Comisión acerca de sus reclamos. Si usted desea que alguien que lo esté representando o asistiendo tenga acceso a su archivo, necesita primero proporcionar aprobación por escrito antes de que lo puedan obtener.

Sus responsabilidades en el sistema Tejano de compensación para trabajadores

Usted tiene la responsabilidad de notificar a su patrón de su lesión o enfermedad

Usted debe notificar a su patrón *dentro de 30 días* desde la fecha que se lesionó, o *dentro de 30 días* desde de la fecha en que usted se enteró primero que su lesión o enfermedad pudo haber sido relacionada con su trabajo. Usted, o la persona que le esté ayudando puede hablar con o escribir al patrón o a cualquier supervisor donde usted esté trabajando.

Si usted no notifica a su patrón dentro de 30 días desde la fecha de su lesión, puede perder su derecho a beneficios.

« ***Usted tiene la responsabilidad de llenar un formulario de reclamo y enviarlo a la Comisión***

Usted debe completar y enviar su formulario de reclamo, que se llama TWCC-41, a la Comisión *dentro de un año* de la fecha en que se enteró que su lesión o enfermedad pudo haber sido relacionada con su trabajo.

Envíe el formulario a la Comisión aunque esté recibiendo beneficios.

Si usted no envía el formulario dentro de un año, usted puede perder el derecho de recibir beneficios. Para obtener una copia del formulario, llame a la oficina local que está manejando su reclamo o llame al 1-800-252-7031.

Usted tiene la responsabilidad de notificar a la Comisión y a la compañía de seguros cada vez que cambien sus ingresos

Si usted *no* está recibiendo beneficios y ha cambiado de trabajo desde su lesión, avise a la Comisión si su lesión le causa faltar al trabajo o perder sueldo. Llame al 1-800-252-7031.

Si usted *está* recibiendo beneficios y ha cambiado de trabajo desde su lesión, avise a la Comisión y la compañía de seguros que le está pagando sus beneficios si hay un cambio de ingresos. Avise a la Comisión o la compañía de seguros a pesar de que suban o bajen sus ingresos. Si usted ha dejado de trabajar desde el día de su lesión, avise a la Comisión y la compañía de seguros si empieza a trabajar de nuevo o tiene oferta de empleo.

— ***Usted tiene la responsabilidad de avisar a su médico como se lesionó y si cree que su lesión puede ser relacionada con el trabajo***

Si es posible, avise a su médico antes de que le dé tratamiento médico.

Ⓡ ***Usted tiene la responsabilidad de avisar a la Comisión y a la compañía de seguros como se pueden comunicar con usted***

Debe avisar a la Comisión y la compañía de seguros de cualquier cambio de domicilio, dirección de trabajo, o número telefónico, para que la Comisión y la compañía de seguros puedan comunicarse con usted cuando sea necesario.

Empresario/Empleador: *Usted debe proveer esta información al trabajador lesionado al mismo tiempo que debe reportar el accidente o lesión a su compañía de seguros. Si su Compañía de seguros está de acuerdo en proveer esta información al trabajador, de todas maneras usted tiene la responsabilidad de asegurar que el trabajador reciba esta información. Esta información debe proveerse en inglés y en español o en el idioma que sea común al trabajador. Esta información puede ser reproducida o fotocopiada tanto como se necesite. Pero no debe ser editado o alterado en ninguna forma. (Reglamento 120.2 de TWCC)*

Texas Workers' Compensation Commission Field Office Ombudsman

Austin Central Office Barton Levy Vacant John C. Cain Juan Mireles Luz Loza	(512) 448-7900 912-2630 440-5676 440-3586 440-3711 440-3733	Harlingen Field Office Inez Jackson	(210) 423-0402 x550
Abilene Field Office Gerri Jimenez	(915) 695-4992 x4550	Houston East Field Office Blake Smith Hattie M. Dugas Linda Tatmon	(713) 643-1330 x1007 x2009 x2008
Amarillo Field Office Linda Marlow	(806) 351-1222 x1550	Houston West Field Office Lisa Lee JoAnn Cavazos-Spann Funke Oresusi Crayton Richardson Patsy Brinson Ardith Taylor	(713) 880-0206 x4047 x4090 x4091 x4152 x4089
Angleton Satellite Office Lupe Olivares	(409) 848-0909 x8681	Laredo Field Office Monica Haynes	(210) 718-2040 x2040
Austin Field Office Tommy Blair	(512) 453-8230 x5555	Lubbock Field Office Janey Aguilar	(806) 744-4569 x555,x550
Beaumont Field Office Pam MacDonald Sabrina Alfaro	(409) 838-3001 x551 x550	Lufkin Field Office Reba Hutson	(409) 639-6425 x6425
Bryan Field Office Irma Benavides	(409) 361-9000 x9016	McAllen Satellite Office Mary Rodea	(210) 618-2716 x2716
Corpus Christi Field Office Lucy Garcia Iglesias	(512) 883-2551 x6405	Midland/Odessa Field Office Romeo Rodriguez	(915) 699-1281 x550
Dallas Field Office Laura Davis Judy Bouchum Paige Jones Jana Sumruld Jose R. Olivares Debra Searcy	(214) 350-9299 x1110 x1112 x1056 x1111 x1113 x1012	San Angelo Field Office Pete Galvan	(915) 657-0404 x0404
Denton Field Office June Mitchell Edith Leanburg	(817) 380-1400 x1433 x1411	San Antonio Field Office Barbara Stewart Mary Rodriguez-Torres Willie Mojica Doug Williams	(210) 593-0070 x1188 x3016 x3019 x3017
El Paso Field Office Veronica Maynez Leticia Jimenez Belinda Callejo Mary Valenzuela	(915) 757-8081 x552 x553 x550 x551	Sugar Land Satellite Office Clara Caldwell	(713) 491-9800 x9800
Fort Worth Field Office Art Gonzales Shawnee Ray Jami Wiertel Tina Ramirez Don Sharlow	(817) 735-4216 x4216 x1034 x1024	Tyler Field Office Israel R. Galindo Betty Troyer David Braley	(903) 534-6250 x550 x551 x552
Galveston Field Office Eduardo Zamora	(409) 744-5773 x5773	Victoria Field Office Norma Gonzalez	(512) 576-9612 x9612
		Waco Field Office Vickie Uptmor	(817) 741-6165 x550
		Wichita Falls Field Office Virginia Joiner	(817) 767-2691 x530