RPS Atlas Workers' Compensation Program 040997

Gallagher Bassett Texas WC Claims Kit for Endurance Assurance Corporation Claims

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Accident Reporting Instructions

FOR SERIOUS OR LIFE-THREATENING INJURIES, CALL 911 OR TAKE EMPLOYEE TO NEAREST EMERGENCY ROOM IMMEDIATELY

Effective 7/1/2025 forward, Gallagher Bassett is the claims administrator for RPS Atlas's workers' compensation Endurance Assurance Corporation claims. Claims should be reported via one of the following methods:

1) **Telephonic reporting:** 833-378-4031
2) **Fax:** 866-668-7780
   - Please use the attached claim reporting form
3) **Email reporting**: Atlasworkcompclaims@gbtpa.com
   - Please use the attached claim reporting form

- Report all accidents/injuries immediately. Delays in reporting can significantly increase claim costs.
- Reporting a claim is NOT an admission that the claim is compensable. GB will investigate all accidents and determine if workers' compensation benefits are due.

Helpful information to have on hand when reporting new incidents:

CLIENT INFORMATION

- Client Number: Your GB client number is **040997**

INJURED EMPLOYEE INFORMATION

- Name
- Employee ID number
- Social security number
- Date of Birth
- Address and home phone number
- Personal email address
- Date of hire
- Marital Status
- Number of dependents
- Policy number (if known)
- Policy effective date (if known)

ACCIDENT INFORMATION

- Date and time of injury
- Location (city and state) of employer location
- Specific description of injury (i.e., employee slipped and fell on wet floor in warehouse)
- Any unsafe behavior that contributed to the accident
- Name and address of injured employee's physician or facility, if treatment already obtained for the injury

Gallagher Bassett Customer Support

GB Toll Free 833-707-6338

Obtaining medical care for your injured employee:

FOR SERIOUS OR LIFE-THREATENING INJURIES, CALL 911 OR TAKE EMPLOYEE TO NEAREST EMERGENCY ROOM IMMEDIATELY

To locate in-network providers near your locations at:

www.talispoint.com/cvty/gbppo

Through this site you can choose from several options to request the providers. Searches can be done by address, name, region, as well as a quick search which is a preformatted search using a limited number of specialties for providers who provide initial treatment of WC injuries only. Outcome Based Network (OBN) providers are identified by a rainbow circle design before their name. The site also provides you with the capability of creating your own preformatted worksite posters. There is also a selection to look up state rules which gives you a brief description of the state rules that apply to your direction of medical care for each state.

GB Care Pharmacy Benefit Management Program

First Fill Program – this program allows the injured employee to obtain their first fill of medication with no out-of-pocket expense to the employee. When filling a prescription, injured workers simply present the First Fill information to the pharmacy. Once the pharmacy verifies eligibility, injured employees are enrolled.

With over 68,000 contracted pharmacies, including all major pharmacy chains, our unique program design enables injured workers to receive prescriptions without incurring out of pocket expenses and ensures appropriate medications are dispensed during each stage of recovery. The injured employee can also call 1.844.276-2515 to find participating pharmacies.

Benefits of the program include:

- No out-of-pocket expense for injured workers. Injured employees can fill their prescriptions on demand (up to 30-day supply of medical) simply by presenting their myMatrixx information to the pharmacy.
- Home Delivery Programs – for qualified injured employees, myMatrixx offers home delivery of medications. Depending upon past use and type of injury, the system automatically identifies those who might benefit, providing added convenience and promoting their recovery.

Occupational Injury Temporary Prescription ID Card

GBCARE | myMatrixx by Evernorth

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 844-276-2515.

Atención Trabajador Lesionado:

Este formulario de identificación para servicios temporales de prescripción de recetas por compensación del trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es).

Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 844-276-2515.

To the Pharmacist:

myMatrixx, an Express Scripts company administers this occupational accident prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 30-day supply or a cost of $500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 844-276-2515.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

myMatrixx, an Express Scripts Company

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: _____ / _____ / _____
MM/DD/YYYY

Group #: NZEA

Employee Date of Birth: _____ / _____ / _____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

RPS Atlas Workers Compensation Program

Occupational Injury Temporary Prescription ID Card

Participating Retail Network Pharmacies

A & P
Acme Pharmacy
Albertson's
Albertson's/Acme
Albertson's/Osco
Albertson's/Sav-On
Amerisource Bergen
Anchor Pharmacies
Arrow
Aurora
Bartell Drugs
Bigg's
Bi-Lo
Bi-Mart
BJ's Wholesale Club
Brooks
Brookshire Brothers
Brookshire Grocery
Bruno
Carrs
Cash Wise
Coborn's
Costco
Cub
CVS
D&W
Dahl's
Dierbergs
Discount Drugmart
Doc's Drugs
Dominicks
Drug Emporium
Drug Fair
Drug Town
Drug World
Eckerd
Econofoods
EPIC Pharmacy Network
FamilyMeds
Farm Fresh
Farmer Jack
Food City
Food Lion
Gemmel
Giant
Giant Eagle
Giant Foods
Hannaford
H-E-B
Hi-School Pharmacy
Hy-Vee
Jewel/Osco
Kash n Karry
Keltsch
Kerr
Kmart
Knight Drugs
LeaderNet (PSAO)
Longs Drug Store
Major Value
Marsh Drugs
Medic Discount
Medicap
Medistat
Meijer
Minyard
NCS HealthCare
Neighborcare
Network Pharmaceuticals
Northeast Pharmacy Services
Osco
P & C Food Markets
Pamida
Park Nicollet
Pathmark
Pavilions
Price Chopper
Publix
Quality Markets
Raley's
Randalls
Rite Aid
Rosauers
Rx Express
RXD
Safeway
Sam's Club
Sav-On
Save Mart
Schnucks
Scolari's
Sedano
Shaw's
Shop 'N Save
Shopko
ShopRite
Snyder
Stop & Shop
Sun Mart
Super Fresh
Super Rx
Target
Texas Oncology Srvs
The Pharm
Thrifty White
Times
Tom Thumb
Tops
Ukrop's
United Drugs
United Supermarkets
Vons
Waldbaums
Walgreens
Wal-Mart
Wegmans
Weis
Winn Dixie

GBGO Mobile App

- Your injured employee will receive an acknowledgement letter giving them their claim number and resolution manager contact information, along with information on accessing GBGO, our mobile app:

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

gbgo

gbgo
mygbclaim

GBGO® — Taking claims management mobile

In a world that keeps moving, GB delivers the best possible claim experience to both clients and injured workers. Through GBGO, a mobile suite that provides faster and better communication, GB keeps all parties engaged throughout the claims process and improves overall satisfaction with the claim experience.

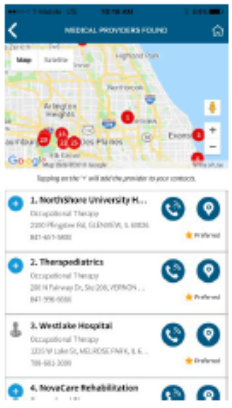
The GBGO MYGBCLAIM App lets injured workers manage their claim anytime, anywhere from their Apple or Android smartphone. The app is secure, easy to use and reliable. The following is a list of features currently supported.

Existing Features

- GBGO SMART bar – Access personalized messages, notifications, reminders, FAQs, and more
- Payments - View benefit payments history and get notifications related to payment updates, enroll in Direct Deposit
- Doctor Appointments - Input your next doctor appointment and let the app track it and remind you.
- Medical Cards - Access digital versions of the Medical Card and the Pharmacy card (Rx Card) with 'one click'.
- Connect with your RM - Phone or email your GB RM (Resolution Manager) with 'one click'.
- Report Release to Return to Work and request your RM (Resolution Manager) to update your contact information from the app.
- FAQs - Access answers to frequently asked questions 24 x7
- App feedback - Tell us what you think
- Experience the app in Spanish
- Pre-Claim Access – Access your Medical Awareness Card (MAC) after your call with the PC365 Nurse
- Claim Contacts – Add, Manage and Access Claim Contacts from one screen – RM, Providers and Pharmacies. Call or get directions to the provider location with one click
- Provider and Pharmacy Search – Search for a Preferred medical provider or pharmacy near you
- Attachments – Send attachments (Doctor Notes, Mileage Reimbursement requests etc.) to your RM directly from the App

Upcoming New Features

- Messaging capabilities



How to:

- Download the app from the Apple or Google app store by following the links below or search for GBGO mygbclaim
- Click on "Register" link at the top of the home screen. Follow the instructions and create an account to start accessing information about your claim
- In case of questions do not hesitate to email or call-us using the links at the bottom of the home page

For Apple devices:

Download on the App Store

For Android Devices:

GET IT ON Google Play

WHEN PEOPLE ARE EMPOWERED THEY CAN ACHIEVE AMAZING THINGS. THAT'S THE POWER OF GBGO.

GALLAGHER BASSETT
GUIDE. GUARD. GO BEYOND.

gbgo

mygbclaim

GBGO®— Llevando la administración móvil de reclamos

En un mundo que sigue en movimiento, GB ofrece la mejor experiencia de reclamo posible tanto para clientes como para trabajadores lesionados. A través de GBGO®, una suite móvil que brinda una comunicación más rápida y mejor, GB mantiene a todas las partes involucradas a lo largo del proceso de reclamos y mejora en general la satisfacción con la experiencia del reclamo.

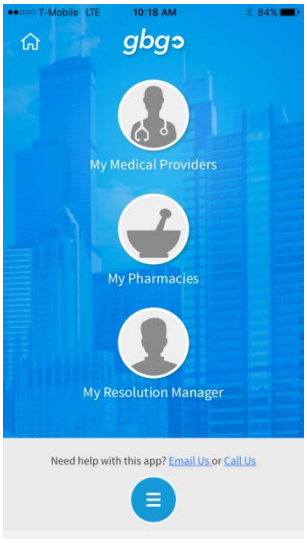
La aplicación GBGO MYGBCLAIM permite a los trabajadores lesionados gestionar su reclamo en cualquier momento y en cualquier lugar desde su teléfono inteligente Apple o Android. La aplicación es segura, fácil de usar y confiable. La siguiente es una lista de las funciones actualmente soportadas.

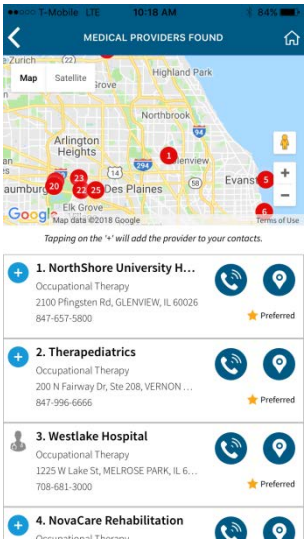
Funciones existentes

- GBGO® SMART bar - Acceder a mensajes personalizados, notificaciones, recordatorios, preguntas frecuentes y más.
- Pagos - Ver el historial de pago de prestaciones y recibir notificaciones relacionadas con las actualizaciones de pago.
- Citas Médicas - Ingrese su próxima cita con el médico y permita que la aplicación la rastree y le envíe un recordatorio.
- Tarjetas médicas - Acceda a las versiones digitales de la Tarjeta médica y la Tarjeta de la farmacia (Tarjeta Rx por sus siglas en Inglés) con 'un clic'.
- Conéctese con su Gerente de Resolución (RM por sus siglas en Inglés) - Por teléfono o envíe un correo electrónico a su GB RM con 'un clic'.
- Reporte la Alta de Regreso a Labores y solicite a su Gerente de Resolución (RM por sus siglas en Inglés) que actualice su información de contacto desde la aplicación.
- Preguntas frecuentes - Acceda a las respuestas a las preguntas frecuentes 24 x 7.
- Comentarios de la aplicación - Díganos lo que piensa.
- Experimente la aplicación en español

Nuevas funciones (serán liberadas el 14 de mayo)

- Acceso previo al reclamo - Acceda a su tarjeta de reconocimiento médico (MAC, por sus siglas en inglés) después de su llamada con la enfermera PC365.
- Contactos del Reclamo - Agregue, administre y acceda a los contactos del reclamo desde una pantalla - Gerente de Resolución, Proveedores y Farmacias. Llame u obtenga indicaciones sobre la ubicación del proveedor con un clic.
- Búsqueda de proveedores y farmacias - Busque un proveedor médico o farmacia preferida cerca de usted.
- Archivos Adjuntos - Envíe archivos adjuntos (notas del médico, solicitudes de reembolso de millas, etc.) a su Gerente de Resolución directamente desde la aplicación.





Cómo:

- Descargar la aplicación desde App Store o Google Play siguiendo los enlaces que se muestran en la parte inferior o busque GBGO® mygbclaim.
- Haga clic en el enlace "Registrarse" en la parte superior de la pantalla de inicio. Siga las instrucciones y cree una cuenta para comenzar a acceder a la información sobre su reclamo
- En caso de preguntas, no dude en enviarnos un correo electrónico o llamarnos usando los enlaces en la parte inferior de la página de inicio

Para dispositivos Apple:

Download on the App Store

Para dispositivos Android:

GET IT ON Google Play

CUANDO LAS PERSONAS ESTÁN EMPODERADAS, PUEDEN LOGRAR COSAS INCREÍBLES. ESE ES EL PODER DE GBGO.

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)	2. Address (street or PO box, city, state, ZIP code)		
3. Phone number	4. Email address	5. Social Security number (X)OOOOOOO()	6. Date of birth (mm/dd/yyyy)
7. Marital status	8. Sex Female Male Othe		
9. Spouse's name (first, middle, last)		10. Number of dependent children	
11. Does the employee speak	Yes No If no, specify language		
12. Doctor's name (first, last)	13. Doctor's mailing address (street or PO box, city, state, ZIP code)		

Part 2: Iniury information

14. Date of injury or illness (mm/dd/yyyy)	15. Time of injury a.m. or p.m.	16. First day absent from work (mm/dd/yyyy)
17. Supervisor's name (first, last)		18. Date injury reported (mm/dd/yyyy)
19. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)		20. Body parts affected

21. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)

22. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)

23. Was the employee doing their regular job? Yes No

24. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)

25. List all witnesses (first, last names)

26. Number of days absent from work, not including the day of injury or the day of return to work

One day or less (work-related illness only) _____ Two to seven days _____ Eight days or more

27. Return-to-work date (mm/dd/yyyy)	**28. Did the employee die?**
Actual date or Expected date	Yes No

Part 3: Employment information

26. Date of hire (mm/dd/yyyy)	**27. Occupation of injured employee**
28. Length of service in current position Years	**29. Length of service in current occupation** Years
30. Employee payroll classification code	**31. Was the employee hired or recruited in Texas?** Yes No

32. Rate of pay at this job	**33. Full work week is**	**34. Last paycheck was**
$ Hourly $ Weekly		$ for Hours or Days

35. Is the employee an owner, partner, or corporate officer? Yes __ No

Part 4: Employer information

36. Name and title of person completing form (first, middle, last, title)	**37. Business name**	
38. Business mailing address (street or PO box, city, state, ZIP code)	**39. Phone number**	**40. Email address**
41. Business location (if different from mailing address)	**42. Federal employer identification number**	
43. Primary North American Industry Classification System (NAICS) code (six digits)	**44. Specific NAICS code** (six digits)	**45. Texas comptroller taxpayer number**
46. Workers' compensation insurance carrier	**47. Policy number**	

48. Did you request accident prevention services in the past 12 months? Yes No

If yes, did you receive them? Yes ___ No

Part 5: Certification

49. Certify with your signature:

I certify the information in this form is true and correct.

Signature_____ **Date** _____

FAQ
Employer's first report of injury or illness

Who do I send this form to?
Send this form to your workers' compensation insurance carrier and to the injured employee or the injured employee's representative. Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation (DWC), unless DWC specifically requests it.

When do I need to send this form?
You must send the DWC Form-001 within eight days after:

1. The employee's first day of absence from work due to the injury;
2. You receive notice of occupational disease; or
3. An employee dies.

Why do I need to send this form?
Employers must file this form so the insurance carrier has the information they need to begin the claims process. You may be fined if you fail to send this report without having a good reason (good cause.)

How should I send this form?
You can file the form with the insurance carrier and send it to the injured employee or the injured employee's representative by email, fax, U.S. Postal Service, or personal delivery.

Do I need to keep a copy of this form?
Yes, you should keep a copy of this form to serve as the Employer's Record of Injury required by Texas Labor Code Section 409.006. For more requirements refer to DWC rule 120.2, *Employer's first report of injury and notice of injured employee rights and responsibilities.*

Questions?
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's wage statement

Section 1: Injured employee information

1. Name (first, middle, last)	**2. Social Security number** (last four digits) XXX-XX-
3. Address (street or PO Box, city, state, ZIP code)	**4. Phone number**
5. Date of injury (mm/dd/yyyy)	**6. Date of hire** (mm/dd/yyyy)
7. First day of missed work (mm/dd/yyyy)	**8. Returned to work on** (mm/dd/yyyy) ☐ **Has not returned to work**

Section 2: Employer information

9. Name	**10. Address** (street or PO box, city, state, ZIP code)
11. Phone number	**12. Federal tax ID number**
13. Printed name (person submitting form)	**14. Job title** (person submitting form)

Section 3: Employment status at the time of injury

15. Check all that apply:

- ☐ **Full-time:** The employee regularly works 30 hours or more per week.
- ☐ **Part-time regular course of conduct:** The employee regularly works less than 30 hours per week.
- ☐ **Part-time not regular course of conduct:** The employee's work history for the 12-month period before the date of injury shows part-time and full-time work.
- ☐ **Seasonal:** The employee does temporary work to meet the employer's needs during certain times of the year.
- ☐ **Apprentice:** The employee is learning a new skilled trade by on-the-job training and studies.
- ☐ **Minor:** The employee is under 18 years of age and not married or emancipated by court action.
- ☐ **Student:** The employee is enrolled in a course of study (such as high school, college, or technical training).
- ☐ **Trainee:** The employee is being trained for the job they were originally hired to do.

Section 4: Wages and benefits (complete parts one and two)

Part 1: Wage information

16. The wage information on this form is for ☐ the injured employee **or** ☐ a similar employee.

17. Salary amount (if applicable)	18. Hourly rate (if applicable)	19. Daily pay (if applicable)	20. Other (if applicable)
$	$	$	$

Week	21. Number of hours worked	22. Pay period dates (mm/dd/yyyy-mm/dd/yyyy)	23. Gross wage amount
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
		24. Total gross wages	

Part 2: Nonpecuniary wage information (paid by employer only for injured employees)

List the amount of nonpecuniary wages in each pay period before the date of injury. Nonpecuniary wages are noncash benefits such as education fees or uniforms. Don't include cash allowances or stipends paid to allow the employee to purchase benefits. Those should be included as wages in box 20.

25. Nonpecuniary wages – complete below:

Yes	☐	☐	☐	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐	☐	☐	☐
Pay Period Week	**a. Health insurance**	**b. Laundry/ cleaning**	**c. Clothing/ uniforms**	**d. Lodging/ housing**	**e. Food/ meals**	**f. Vehicle/ fuel**	**g. Professional licenses**	**h. Other**
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

26. Check if continued after date of injury:

☐	☐	☐	☐	☐	☐	☐	☐

27. Date ended (mm/dd/yyyy)

28. Certify with your signature.

I certify the information provided in this form is true and correct.

Signature_____ **Date**_____

FAQ

Employer's wage statement

When must an employer file the DWC Form-003, *Employer's Wage Statement*?
An employer must file the completed form with the insurance carrier, the injured employee, and the injured employee's representative (if any) within 30 days from the earliest of:

- the date the employer is notified that the employee is entitled to income benefits; or
- the date the employee's death is a result of the injury (compensable); and
- within seven days from getting a request from the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Note: An employer who fails to timely file a complete wage statement without good cause, as required by Texas Labor Code Section 408.063(c) and 28 Texas Administrative Code (TAC) Section 120.4(a), may be fined.

How do I report wages?
Report all wages **paid in the 13 weeks before the date of injury** according to the employee's pay period. Employers may report 14 weeks if paid biweekly or three months if paid monthly. In all cases, list the dates that each period covers.

- If the employee was **not employed for 13 weeks** before their injury, report wages of an employee who has the training, experience, skills, same pay, and same number of hours.
- If **no similar employee exists**, report all wages the injured employee earned before the injury (28 TAC Section 120.4).

Do I have to report non-pecuniary benefits?
Report all benefits paid to the employee in **a form other than money**. This includes, but is not limited to, the benefit categories listed in Section 4, Part 2.

What if my employee has multiple jobs?
The injured employee will submit the DWC Form-003ME, *Employee's Multiple Employment Wage Statement* to their other employer. The injured employee will submit the completed form to the insurance carrier (28 TAC Section 122.5).

What is average weekly wage?
The gross average amount of money the employer paid the injured employee each week in the 13 weeks before the injury or illness.

Questions?
Call 1-800-252-7031, Monday to Friday, 8 a.m. to 5 p.m., Central time. Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Supplemental report of injury

Part 1: Employer information

1. Name		2. Address (street or PO box, city, state, ZIP code)
3. Phone number	4. Email address	5. Insurance carrier name

	Yes	No
6. Does the employer have return-to-work (RTW) opportunities available based on the injured employee's current capabilities? If yes, give a contact name and phone number:	☐	☐
7. Has the insurance carrier provided RTW coordination services within the past 12 months? If yes, give the date: (mm/dd/yyyy)	☐	☐
8. Has the employer requested RTW training from DWC or the insurance carrier?	☐	☐
9. Has the insurance carrier provided accident prevention services in the past 12 months? If yes, give the date: (mm/dd/yyyy)	☐	☐
10. Has the employer requested accident prevention services from the insurance carrier?	☐	☐

Part 2: Reason for filing this report

11. ☐ a. The injured employee returned to work in either full or limited capacity: file this report within three days.

☐ b. The injured employee returned, then later had more lost time or reduced wages because of the injury: file this report within three days.

☐ c. The injured employee is earning more or less than the pre-injury wage because of the injury: file this report within 10 days after each pay period that the injured employee's earnings changed.

☐ d. The injured employee resigned or was terminated from employment: file this report within 10 days.

Part 3: Injured employee information

12. Name (first, middle, last)	**13. Address** (street or PO box, city, state, ZIP code)	**14. Phone number**
15. Email address	**16. Date of injury** (mm/dd/yyyy)	**17. Social Security number** [(last four digits) XXX-XX-
18. First day absent from work or had reduced wages because of the injury (mm/dd/yyyy)	**19. First day of additional absence from work or reduced wages because of the injury** (mm/dd/yyyy)	

20. Has the injured employee experienced eight days (cumulative) of lost time or reduced wages because of the injury? Yes ☐ No ☐ **If yes, what is the date of the eighth day?** (mm/dd/yyyy)

21. Date of most recent RTW (mm/dd/yyyy) **:**

☐ Full duty, full pay ☐ Limited duty, full pay **or** ☐ Limited duty, reduced pay

22. Has the injured employee resigned, been terminated, or died? Yes ☐ No ☐

22a. If yes, was it a resignation, termination, or death? **On what date?** (mm/dd/yyyy)

22b. What was the reason for the resignation or termination?

22c. Was the injured employee on limited duty when terminated? Yes ☐ No ☐

23. How many hours did the injured employee work during the most recent pay period of:

(mm/dd/yyyy) **to** (mm/dd/yyyy) **? hours per week.**

23a. Are these hours the same as pre-injury? Yes ☐ No ☐

23b. If no, are these hours less than or more than pre-injury hours? ☐ Less than ☐ More than

24. What were the injured employee's weekly or hourly earnings for the most recent pay period of:

(mm/dd/yyyy) **to** (mm/dd/yyyy) **?** $ weekly **or** $ hourly

24a. Are these wages the same as pre-injury? Yes ☐ No ☐

24b. If no, are these wages less than or more than pre-injury wages? ☐ Less than ☐ More than

Part 4: Certification

25. Certify with your signature:

- To the best of my knowledge, the information in this report is accurate and may be used to evaluate eligibility for benefits.
- **Submitted by:** ☐ Employer **or** ☐ Injured employee (*If no longer working for the employer where the injury occurred*)

Signature_____ **Date**_____

FAQ

Supplemental report of injury

Why do I need to file this form?
The Texas Department of Insurance, Division of Workers' Compensation (DWC) requires either the employer or the injured employee to report to the insurance carrier all return-to-work activity and post-injury change of earnings. This allows the insurance carrier to adjust the weekly amount of temporary income benefits (TIBs) paid to an injured employee to match the changes in weekly earnings after the injury.

Who is responsible for filing this form?
Either the employer or the injured employee.

Employer: The employer that the injured employee was working for at the time of the on-the-job injury must send this form to the insurance carrier and the injured employee while the injured employee is receiving TIBs and until the injured employee reaches maximum medical improvement or is no longer employed by the employer.

Injured employee: If you are no longer working for the employer where the on-the-job injury occurred, and you are receiving benefits, then you must let the workers' compensation insurance carrier know if your wages changed or if you have received any offers of employment.

If you are not receiving benefits, you must tell the insurance carrier if the injury caused you to miss work or lose income.

How do I send this form?
Send this form to the insurance carrier by email, fax, telephone, or personal delivery. The employer must provide a copy of the form to the injured employee by email, fax, mail, or personal delivery.

Questions?
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.

TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

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."

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USTED PUEDE USAR SU PROPIO MEMBRETE CON LA SIGUIENTE INFORMACIÓN

Reglamento de Referencia 110.101

(a) Además del aviso que debe ponerse a la vista, el cual es requerido por la sub sección (e) de esta sección, los empleadores, según lo definido por la Sección del Código Laboral 406.001, deberán notificar por escrito a sus empleados sobre el estado de la cobertura de compensación para trabajadores. Además, este aviso:

(1) deberá ser proporcionado al momento en que el empleado es contratado, es decir, cuando la ley federal requiere que el empleado complete el formulario W-4 y el formulario I-9, o cuando haya ocurrido una interrupción en el servicio y la ley federal requiere que el empleado complete el formulario W-4 en el primer día en que el empleado se reporta de regreso a sus deberes;

(2) deberá ser proporcionado a cada empleado, por un empleador cuya cobertura de seguro de compensación para trabajadores ha sido anulada o cancelada, a no más tardar del día 15, después de la fecha en la cual la anulación o cancelación entra en vigor;

(3) deberá ser proporcionado a cada empleado, por un empleador que obtiene una cobertura de seguro de compensación para trabajadores, a no más tardar del día 15, después de la fecha en la cual la cobertura entra en vigor, según lo necesario para permitir que el empleado opte por conservar su derecho común (common law right, por su nombre en inglés) bajo el Capítulo 406 del Código Laboral;

(4) deberá incluir el texto que es requerido en el aviso que debe ponerse a la vista (ver el reglamento 110.101 (e)(1), (e)(2), (e)(3), (e)(4) para obtener el lenguaje apropiado); y

(5) si el empleador está cubierto por un seguro de compensación para trabajadores (subscriptor) u obtiene una cobertura, ya sea mediante un seguro comercial o se convierte en auto asegurado según lo proporcionado por la Ley de Compensación para Trabajadores de Texas (Ley), deberá incluir la siguiente declaración:

AVISO A LOS NUEVOS EMPLEADOS

"Usted puede optar por conservar su derecho común de acción de ley (common law right of action, por su nombre en inglés) si, a no más tardar de cinco días después que usted comienza su empleo o dentro de cinco días después de recibir aviso por escrito por parte del empleador donde se informa que el empleador ha obtenido una cobertura de seguro de compensación para trabajadores, usted le notifica a su empleador por escrito que desea conservar su derecho común de acción de ley para recuperarse de daños por lesiones personales. Si opta por conservar su derecho común de acción de ley, usted no puede obtener beneficios médicos o de ingresos de compensación para trabajadores si se ha lesionado."

TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Quy tắc dẫn chiếu 110.101

(a) Ngoài thông báo được niêm yết theo yêu cầu tại tiểu mục (e) của mục này, các chủ nhân, như được định nghĩa tại Mục 406.001 của Bộ Luật Lao Động, phải thông báo bằng văn bản cho các nhân viên của mình về tình trạng phạm vi bảo hiểm bồi thường lao động. Thông báo bổ sung này:

(1) sẽ được cung cấp vào thời điểm nhân viên được thuê tuyển, có nghĩa là khi nhân viên được pháp luật liên bang yêu cầu phải hoàn tất cả mẫu W-4 và mẫu I-9 hoặc khi đã xảy ra sự gián đoạn trong công việc, và nhân viên được pháp luật liên bang yêu cầu phải hoàn tất mẫu W-4 vào ngày đầu tiên nhân viên trở lại làm việc;

(2) sẽ được cung cấp cho mỗi nhân viên, bởi chủ nhân khi phạm vi bảo hiểm bồi thường lao động bị chấm dứt hoặc huỷ bỏ, không trễ hơn ngày thứ 15 sau ngày phạm vi bảo hiểm bị chấm dứt hoặc huỷ bỏ có hiệu lực;

(3) sẽ được cung cấp cho mỗi nhân viên, bởi chủ nhân nhận được phạm vi bảo hiểm bồi thường lao động, không trễ hơn ngày thứ 15 sau ngày phạm vi bảo hiểm đó có hiệu lực, để cho phép nhân viên lựa chọn tiếp tục các quyền lợi cần thiết theo thông luật theo Chương 406 Đạo Luật Lao Động;

(4) sẽ bao gồm cả phần nội dung được yêu cầu trong thông báo được niêm yết (xem quy tắc 110.101 (e)(1), (e)(2), (e)(3), (e)(4) để sử dụng ngôn ngữ phù hợp); và

(5) nếu chủ nhân có phạm vi bảo hiểm bồi thường lao động (có ghi danh) hoặc được phạm vi bảo hiểm, dù qua bảo hiểm thương mại hoặc qua hình thức tự bảo hiểm như được quy định bởi Đạo Luật Bồi Thường Lao Động Tiểu Bang Texas (Đạo Luật), sẽ bao gồm tuyên bố sau:

THÔNG BÁO GỬI CHO CÁC NHÂN VIÊN MỚI

"Bạn có thể chọn tiếp tục các quyền lợi cần thiết của mình theo thông luật nếu, không quá 5 ngày sau khi bạn được tuyển dụng hoặc trong vòng 5 ngày sau khi nhận được văn bản thông báo của chủ nhân rằng chủ nhân đã có bảo hiểm bồi thường lao động, bạn báo cho chủ nhân của bạn bằng văn bản là bạn muốn tiếp tục các quyền lợi cần thiết của mình theo thông luật để bù đắp cho thiệt hại đối với thương tích cá nhân. Nếu bạn chọn tiếp tục các quyền hành động theo thông luật, bạn không thể nhận được lợi tức hoặc những quyền lợi về y tế từ bồi thường lao động nếu bạn bị thương tích."

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.

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

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

THÔNG BÁO CHO CÁC NHÂN VIÊN VỀ VIỆC BỒI THƯỜNG LAO ĐỘNG Ở TEXAS

PHẠM VI BẢO HIỂM: [Tên chủ nhân] _____ _____ có phạm vi bảo hiểm bồi thường lao động của [tên công ty bảo hiểm thương mại] _____ _____trong trường hợp có những thương tích liên quan đến công việc hoặc những bệnh tật do nghề nghiệp tạo ra. Phạm vi bảo hiểm này có hiệu lực từ [ngày hiệu lực của hợp đồng bảo hiểm lao động] _____. Bất cứ thương tích hoặc bệnh tật do nghề nghiệp tạo ra xẩy ra vào ngày hoặc sau ngày đó sẽ được giải quyết bởi [tên của công ty bảo hiểm thương mại] _____ _____. Một nhân viên hoặc một người có quyền thay mặt người nhân viên đó phải thông báo cho chủ nhân về thương tích hoặc bệnh tật do nghề nghiệp tạo ra không quá ngày thứ 30 sau ngày thương tích xảy ra hoặc ngày mà nhân viên biết hoặc lẽ ra phải biết về bệnh tật do nghề nghiệp tạo ra, trừ phi Cơ Quan Bảo Hiểm Tiểu Bang Texas, Ban Bồi Thường Lao Động (Ban) xác nhận rằng việc không thông báo kịp thời là có nguyên nhân chính đáng và hợp lý. Chủ nhân của bạn bắt buộc phải cung cấp cho bạn những thông tin liên quan đến việc bảo hiểm, bằng văn bản, khi bạn được thuê tuyển hoặc bất kỳ lúc nào chủ nhân bắt đầu hoặc chấm dứt bảo hiểm bồi thường lao động.

HỖ TRỢ CHO NHÂN VIÊN: Ban Bồi Thường Lao Động cung cấp thông tin miễn phí về cách thức nộp hồ sơ yêu cầu bồi thường lao động. Nhân viên của Ban sẽ trả lời bất cứ câu hỏi nào bạn có thể có liên quan đến việc bồi thường lao động và tiến hành bất cứ yêu cầu nào để giải quyết sự tranh chấp yêu cầu thanh toán. Bạn có thể nhận được sự hỗ trợ này bằng cách liên lạc với văn phòng địa phương của Ban hoặc gọi số 1-800-252-7031. Văn Phòng Cố Vấn Cho Nhân Viên Bị Thương Tích (OIEC) cũng cung cấp sự hỗ trợ miễn phí cho các nhân viên bị thương tích và sẽ giải thích những quyền lợi và trách nhiệm của bạn theo Đạo Luật Bồi Thường Lao Động. Bạn có thể nhận được sự hỗ trợ của OIEC bằng cách liên lạc với người đại diện dịch vụ yểm trợ của văn phòng OIEC địa phương của bạn hay gọi số 1-866-EZE-OIEC (1-866-393-6432).

ĐƯỜNG GIÂY NÓNG VỀ VI PHẠM AN TOÀN: Ban Bồi Thường Lao Động có số điện thoại miễn phí hoạt động 24/24 để nhận báo cáo những dữ kiện mất an toàn nơi làm việc mà có thể vi phạm đến sức khỏe nghề nghiệp và luật an toàn. Luật pháp cấm chủ nhân đình chỉ, sa thải, hoặc phân biệt đối xử với bất kỳ nhân viên nào bởi vì người này đã báo cáo một cách trung thực mọi sự vi phạm về sức khỏe nghề nghiệp hoặc an toàn. Xin liên lạc với Ban Bồi Thường Lao Động ở số 1-800-452-9595.

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.

1. Prominently displayed in the employer's personnel office, if any;2.
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;3.
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in
4. at least 16 point normal type; and4.
5. 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 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.**
   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.**