NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ has workers' compensation insurance coverage from [name of commercial insurance company] BERKLEY INDUSTRIAL COMP 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] BERKLEY INDUSTRIAL COMP _____. 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] BERKLEY INDUSTRIAL COMP _____ 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] BERKLEY INDUSTRIAL COMP _____. 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

TEXAS WORK INJURY REPORTING PROCEDURES

This Claim Kit is provided for your use in reporting all employee job related injuries. Copy the forms as needed.

Employer's First Report of Injury (FROI)

This form, numbered DWC FORM-001, must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to Great Divide Insurance Company. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records). A copy of the First Report and the Notice of Injured Employee Rights and Responsibilities must be given to the injured employee.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the First Report of Injury. Maintain a copy for your records. If you utilize another version of a Supervisor's Report, it may be substituted for this form but please send it to us with the First Report of Injury.

Wage Statement

A wage statement, DWC Form-003, must be completed on any case where it is anticipated that the injured employee might lose work beyond the waiting period of more than one (1) day or an occupational disease is claimed. The State requires reporting of gross wages for the thirteen (13) weeks prior to the accident. If the employee has not been employed for that amount of weeks, report all the wages available. We may inquire about wages for a similar employee of the same class and grade. Remember computation of wages may include, in addition to salary, hourly pay or tips, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee if they constitute a financial benefit to the employee and are capable of monetary calculation. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

If you have any questions, feel free to contact the claim department to assist you.

Please do not hold the First Report of Injury for completion of the wage statement.

Work Status

You must immediately notify Great Divide Insurance Company if an employee begins to lose time from work. Equally important, you must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

TEXAS WORK INJURY REPORTING PROCEDURES

This Claim Kit is provided for your use in reporting all employee job related injuries. Copy the forms as needed.

Employer's First Report of Injury (FROI)

This form, numbered DWC FORM-001, must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer's First Reports of Injury or Occupational Disease (FROI's) may be submitted online at www.berkindcomp.com. Online Reporting Instructions are enclosed. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records). A copy of the First Report, the Notice of Injured Employee Rights and Responsibilities and the Ombudsman Program document must be given to the injured employee.

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted to us. Maintain a copy for your records. If you utilize another version of a Supervisor's Report, it may be substituted for this form but please send it to us with the First Report of Injury.

Wage Statement

A wage statement, DWC Form-003, must be completed on any case where it is anticipated that the injured employee might lose work beyond the waiting period of more than seven (7) days of disability. The State requires reporting of gross wages for the thirteen (13) weeks prior to the accident. If the employee has not been employed for that amount of weeks, report all the wages available. We may inquire about wages for a similar employee of the same class and grade. Remember computation of wages may include, in addition to salary, hourly pay or tips, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee if they constitute a financial benefit to the employee and are capable of monetary calculation. If there are weeks with no wages, please explain the reason by coding as follows:

V= Vacation I= Illness L= Lay off P= Personal leave O= Other

If you have any questions, feel free to contact the claim department to assist you.

Do not delay reporting the Employer's First Report of Injury or Occupational Disease for completion of the Wage Statement.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. Equally important, you must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

DWC FORM-001
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM-001 Rev. 10/05] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

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

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

[Workers' Compensation Rule 120.2]

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

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

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

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

An employer who fails to file the report without good cause may be assessed an administrative penalty. 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 Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

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

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

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

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

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F ☐ M ☐	15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -	18. Nature of Injury*	19. Part of Body Injured or Exposed*	
6. Does the Employee Speak English? YES ☐ NO ☐ If No, Specify Language			20. How and Why Injury/Illness Occurred*		
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐		21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
9. Mailing Address Street or P.O. Box			23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site		
City	State	Zip Code County	Street or P.O. Box	County	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐			City	State	Zip Code
11. Number of Dependent Children	12. Spouse's Name		24. Cause of Injury(fall, tool, machine, etc.)*		
13. Doctor's Name			25. List Witnesses		
14. Doctor's Mailing Address (Street or P.O.Box)			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) - -
City	State	Zip Code			

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $_____Hourly $_____Weekly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: $_____ for ___ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )		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.
48. Workers' Compensation Insurance Company		49. Policy Number	

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

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

Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT (DWC Form-003)

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

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

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

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

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

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

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

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

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

EMPLOYEE AND EMPLOYER INFORMATION

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

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

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

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

Signature: _____ Date: _____

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

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

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

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

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

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

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

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

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

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

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

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

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

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																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.

Texas Department Of Insurance

Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-94
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.texas.gov

DWC Claim#
Carrier Claim#

← Send the completed form to this address.

Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one year** of the date of injury or within one year from the date the injured employee knew or should have known the injury or disease may be work-related.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	**E-Mail address**	**Sex** ☐Male ☐Female
Race / Ethnicity ☐White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐Separated ☐Single ☐Divorced		
Do you have an attorney or other representation? ☐Yes ☐No **If yes, name of representative**		
Have you returned to work? ☐Yes ☐No	**If returned to work, date returned** (mm/dd/yyyy)	**Work status** ☐Regular ☐Restricted
Occupation at time of injury		**Date of hire** (mm / dd / yyyy)
Hired or recruited in Texas ☐ Yes ☐ No	**Pre-tax wages** (at the time of injury) $	☐hourly ☐ weekly ☐monthly

II. INJURY INFORMATION

I am reporting an ☐ injury **or** ☐ occupational disease	**Date of injury** (mm / dd / yyyy)	**Time of injury**
First work day missed (mm / dd / yyyy)	**Date injury was reported to the employer** (mm / dd / yyyy)	
Where did the injury occur? County	**State**	**Country**
If accident occurred outside of Texas, on what date did you leave Texas? (mm/dd/yyyy)		
Witness(es) to the injury (list by name)		
Describe cause of injury or occupational disease, including how it is work related		
Body part(s) affected by the injury		
If injury is the result of an occupational disease: **1. On what date was the employee last exposed to the cause of the occupational disease?** (mm / dd / yyyy) **2. When did you first know occupational disease was work related?** (mm / dd / yyyy)		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name**

IV. DOCTOR INFORMATION

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	
Name of workers' compensation health care network, if any	

Signature of injured employee or person filling out this form on behalf of injured employee **Date**

Printed name of injured employee or person filling out form on behalf of injured employee

Information about Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

A claim for Workers' Compensation benefits must be filed with the Division of Workers' Compensation (Division) by the injured employee (you), or by a person acting on the injured employee's (your) behalf within *one year* of the injury or within *one year* from the date you knew or should have known the injury or disease may be work related; UNLESS good cause exists for the failure to timely file a claim, or the employer or the employer's insurance carrier does not contest the claim.

Upon receipt of your completed DWC Form-041, or other notice of your injury, the Division will create a claim and establish a DWC claim number for you, and the Division will mail information regarding workers' compensation in Texas to you. The Division will also notify your employer and the employer's workers' compensation insurance carrier.

SPECIAL INSTRUCTIONS AND INFORMATION FOR COMPLETING THE DWC Form-041

General Instructions

- **Complete all boxes in the DWC Form-041**.
- If you have questions about completing this form, please call your local Division Field Office at 1-800-252-7031.

Injured Employee Information

- Work Status information
  - If you have returned to your regular job and you are performing the same duties as you were before your injury, check the "Regular" box.
  - If you have been released to work with restrictions by a doctor, check "Restricted."

Injury Information

- An *injury* is damage to your body that was caused by a single incident, accident, or event.
- An *occupational disease* is an illness or injury related to or caused by the work you do, and may include injuries to your body that are the result of repetitive activities you performed on the job over a period of time.

Employer Information

- Provide information about your employer at the time you were injured.

Doctor Information

- If you already have a workers' compensation treating doctor, provide the name and address of the doctor.
- If you are covered under a workers' compensation healthcare network, provide the name of the network.

Contacting Texas Department of Insurance, Division of Workers' Compensation

If you have questions about filling out this form or workers' compensation in Texas, please call your local Division Field Office at 1-800-252-7031.

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information TDI-DWC collects about you; get and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004). For more information, contact agencycounsel@tdi.texas.gov or you may refer to the Corrections Procedure section at www.tdi.texas.gov.

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

Employer's Report of Non-covered Employee's Occupational Injury or Disease

Type or print in black ink

☐ **Non-subscribing Employer**
☐ **Subscribing Employer - Employee Waived Workers' Compensation Insurance Coverage**

I. EMPLOYER INFORMATION

1. Employer Business Name			
2. Reporting Period (mm/yyyy)	**3. Number of Injured Employees Included on This Report**		
4. Employer Business Mailing Address (Street or PO Box, City, County, State, Zip Code)		**5. Provide the following:**	
		NAICS Codes	**NAICS Employment**
6. Employer Physical Address (Street, City, State, Zip Code)			
7. Employer Phone Number			
8. Federal Employer ID Number			
9. Name of Person Completing Form			
10. Phone Number of Person Completing Form			
11. Title of Person Completing Form			
12. Signature of Person Completing Form		**13. Date of Signature** (mm/dd/yyyy)	

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**
22. Race/Ethnic Identification ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (specify)		

For TDI-DWC Use Only

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)	
24. Type of Location Where Injury/Occupational Disease Occurred ☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations	
25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)
27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)	
28. Reported Cause of Injury	
29. Nature of Injury/Occupational Disease	
30. Equipment Involved in the Injury (if any)	
31. Body Part(s) Affected	
32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)
36. Description of Incident	

NOTE[1]: Title 28 Texas Administrative Code, Chapter 160 requires employers to report work-related deaths, on-the-job injuries and occupational diseases in the form and manner required by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004)

Employer's Name: Employer's FEIN:	For TDI-DWC Use Only

Injury Data for Additional Injured Employee(s)
(reproduce this page, if necessary)

Employer Business Name	
Employer FEIN	**Reporting Period** (mm/yyyy)

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**

22. Race/Ethnic Identification
☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
☐ Other (specify)

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)

24. Type of Location Where Injury/Occupational Disease Occurred
☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations

25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)

27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)

28. Reported Cause of Injury

29. Nature of Injury/Occupational Disease

30. Equipment Involved in the Injury (if any)

31. Body Part(s) Affected

32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)

36. Description of Incident

For TDI-DWC Use Only

Frequently Asked Questions
Employer's Report of Non-covered Employee's Occupational Injury or Disease (DWC Form-007)

Which employers are required to report on-the-job injuries, occupational diseases, and work-related deaths on the DWC Form-007?

The following employers are required to file the DWC Form-007:

- An employer that **does not have** workers' compensation insurance coverage (non-subscriber) and **employs five or more employees who are not exempt** from workers' compensation insurance coverage must file the DWC Form-007 to report all on-the-job injuries and occupational diseases. Examples of exempt employees include certain domestic workers, and certain farm and ranch workers.
- An employer that **has** workers' compensation insurance coverage must file the DWC Form-007 to report an on-the-job injury or occupational disease for an **employee who has waived** workers' compensation insurance coverage in accordance with Texas Labor Code §406.034.

Failure to file the form may subject the employer to administrative penalties.

What do I do if I need to report more than two injured employees?
Copy page three of the form as many times as necessary for reporting additional injured employees.

When do I file the DWC Form-007?
The form must be filed not later than the 7th day of the month following the month in which:

- a work-related death occurred,
- an employee was absent from work for more than one day* as a result of an on-the-job injury; or
- the employer acquired knowledge of an occupational disease.

*Do not count the day of the injury or the day the injured employee returned to work when calculating the number of days absent from work.

NOTE: If no such deaths, injuries, or diseases occurred during a calendar month, no report is required for that month.

Are any fields on the DWC Form-007 optional?
No, all applicable fields must be completed each time the DWC Form-007 is filed.

How do I file the DWC Form-007?
Submit the DWC Form-007 to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by:

- faxing the form to (512) 804-4146; or
- mailing the form to the address listed at the top of the form.

Instructions for Completing Specific Items

Box 5: Employer NAICS Codes*/Employment
List all six-digit NAICS Codes which the employer uses with the FEIN specified in Box 8. Provide the highest employment figure for each NAICS Code for the month of the report. Employment means all employees on your payroll whether full-time, part-time, temporary, or permanent. Attach additional pages, if necessary.

Box 21: Employee NAICS Code*
List the six-digit NAICS Code of the activity that the employee was engaged in at the time of the injury or disease. The code listed must be one of the six-digit NAICS Code numbers reported in Box 5.

Box 22: Race/Ethnic Identification
Check appropriate box and provide requested information, if applicable. Information as to the race/ethnicity of the employee will be maintained for non-discriminatory statistical use.

NOTE: Hispanic, while not a race identification, is included as a separate race/ethnic category. Do not include Hispanic under "white" or "black".

Box 28: Reported Cause of Injury
Enter the most probable cause of the injury or disease. Examples: overexertion due to lifting or pushing, caught between, slip, trip, fall.

Box 29: Nature of Injury/Occupational Disease
Enter the type of injury or occupational disease. Examples: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. For multiple injuries, use most serious.

Box 33: Number of Days Absent from Work

- *Occupational disease*: Must be reported regardless of the number of days the employee is absent from work. Check the appropriate box, including *1 Day or Less*.
- *On-the-job injury*: Must be reported only if the employee is absent from work for more than one day. Do not check *1 Day or Less*.

Box 36: Description of Incident
Provide a short narrative of how the incident occurred. Example: While painting house, fell off ladder and fractured arm.

*Information on NAICS Codes can be found on the United States Census Bureau website at www.census.gov/eos/www/naics. NAICS Codes can also be obtained from the *North American Industry Classification System* published by the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161; e-mail: info@ntis.fedworld.gov.

TEXAS WRITTEN NOTICE FOR NEW HIRES

The attached letter must be provided to each new employee upon hire. Please copy it onto your own letterhead. You must also provide the NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS. The letter and NOTICE are attached in both English and Spanish. It is recommended that you keep a copy of the notice provided to each new employee in their personnel file. The notice should be signed and dated by both the employer and employee.

You must also inform them of their right to reject workers' compensation coverage and retain their common law right of action. If an employee wishes to reject workers' compensation coverage, written notification must be provided to you.

Further the NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS must be posted in the personnel office (if you have one) and in prominent places where employees can see it regularly. The NOTICE must be posted in both English and Spanish.

FAILURE TO PROVIDE THE LETTER AND NOTICE TO NEW EMPLOYEES COULD RESULT IN A FINE UP TO $500 PER OCCURANCE

FAILURE TO POST THE NOTICE COULD RESULT IN A FINE UP TO $1000.00

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 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.

OMBUDSMAN SERVICES

WHAT IS AN OMBUDSMAN?

An Ombudsman is a specially trained employee of the Office of Injured Employee Counsel (OIEC) who can assist you if you have a dispute with your employer's insurance carrier free of charge. Each OIEC ombudsman has a workers' compensation insurance claims adjuster's license and has completed a comprehensive training program designed specifically for OIEC ombudsmen. ***Ombudsman services are provided at no cost to injured employees.***

The ombudsman can answer questions you have regarding your dispute (by calling 1-866-EZE-OIEC). And, upon request, the ombudsman can:

- Help you prepare for benefit review conferences;
- Help you prepare for benefit contested case hearings;
- Attend benefit review conferences and benefit contested cases hearing with you and communicate on your behalf with the parties, and;
- Help you prepare appeals and answer carrier appeals to the appeals panel of the Texas Department of Insurance, Division of Workers' Compensation.

Signed_____ Date _____

Signed _____ Date _____

AVISO A NUEVOS EMPLEADOS

**"Usted puede elegir retener su derecho común de acción de ley si, a no más de cinco días
después de haber comenzado su empleo o dentro de cinco días después de haber recibido aviso
por escrito por parte del empleador donde se informa que el empleador ha obtenido cobertura,
notifique a su empleador por escrito que usted desea retener su derecho común de ley para
cobrar por daños por una lesión personal. Si usted elige retener su derecho común de acción
de ley, usted no podrá obtener ingresos de compensación para trabajadores o beneficios
médicos si usted se ha lesionado."**

QUE ES UN OMBUDSMAN?

Un Ombudsman es un empleado especialmente entrenado por la *Oficina de Asesoría Pública para el Empleado Lesionado* (sigla en inglés OIEC) quien puede asistirlo gratis, si usted tiene una disputa en contra de la compañía de seguros de su empleador. Cada ombudsman en OIEC tiene una Licencia de Compensación para Trabajadores como ajustador y ha recibido un programa de entrenamiento completo designado especialmente para empleados de OIEC. ***El servicio del ombudsman es gratis para los empleados lesionados.***

El ombudsman puede ayudarlo con las preguntas que usted tenga acerca de su audiencia (llamando al 1-866-EZE-OIEC). Y, si usted solicita su ayuda, un ombudsman puede:

- Ayudarle a prepararse para una Conferencia para Revisión de Beneficios (sigla en inglés BRC);
- Ayudarle a prepararse para una Audiencia para Disputar Beneficios (sigla en inglés CCH);
- Asistir con usted a la Conferencia para Revisión de Beneficios tanto como a la Audiencia para Disputar Beneficios y puede ayudarle a comunicarse con la persona que representa a la compañía de seguros y con el juez o mediador en un BRC o CCH, además;
- Puede ayudarle a preparar una apelación o a contestar la apelación de la compañía de seguros ante el Panel de Apelaciones del Departamento de Seguros de Texas, División de Compensación para Trabajadores.

Signed _____ Date _____

Signed _____ Date _____

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. 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 the system through the Division of Workers' Compensation.

You can contact the Office of Injured Employee Counsel by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Also, more information is available on the Internet at: **www.oiec.state.tx.us <http://www.oiec.state.tx.us>.**

You can contact the Division of Workers' Compensation by calling the toll-free telephone number 1-800-252-7031. More information about the Division of Workers' Compensation is available on the Internet at: **<http://www.tdi.state.tx.us/wc/indexwc.html>.**

Your Rights in the Texas Workers' Compensation System:

1. **You may have the right to receive benefits.**

You may receive benefits regardless of who was at fault for your injury with certain exceptions, such as:

- You were intoxicated at the time of the injury;
- You injured yourself on purpose or while trying to injure someone else;
- You were injured by another person for personal reasons;
- You were injured by an act of God;
- Your injury occurred during horseplay; or
- Your injury occurred while voluntarily participating in an off-duty recreational, social, or athletic activity.

2. **You have the right to receive medical care to treat your workplace injury or illness. There is no time limit to receive this medical care as long as it is medically necessary and related to the workplace injury.**

3. **Choosing 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.
   - If you are not in a network, you may choose any doctor who is willing to treat your workers' compensation injury.
   - 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.

4. **You have the right to hire an attorney at any time to help you with your claim.**

5. **You have the right to receive information and assistance from the Office of Injured Employee Counsel at no cost.**

Staff is available to answer your questions and explain your rights and responsibilities by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432) or visiting any Division of Workers' Compensation/Office of Injured Employee Counsel local field office.

6. **You have the right to receive ombudsman assistance if you do not have an attorney and a dispute resolution proceeding about your claim has been scheduled.**

An ombudsman is an employee of the Office of Injured Employee Counsel. Ombudsmen are trained in the field of

workers' compensation and provide free assistance to injured employees who are not represented by attorneys. At least one Ombudsman is located in each local field office to assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot sign documents for you, make decisions for you, or give legal advice.

7. You have the right for your 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 the Division of Workers' Compensation.

Your Responsibilities in the Texas Workers' Compensation System

1. You have the responsibility to tell your employer if you have been injured at work or in the scope of your employment.

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. Your employer must give you a copy of the TDI network rules. Read the rules carefully. If there is something you do not understand, ask your employer or call the Office of Injured Employee Counsel. 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.state.tx.us/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 provider 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 claim form (DWC-41) to the Division of Workers' Compensation. 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 DWC-41 form even if you already are receiving benefits. You may lose your right to benefits if you do not send the completed claim form to the Division of Workers' Compensation. Call 1-800-252-7031 or 1-866-393-6432 for a copy of the DWC-41 form.

6. You have the responsibility to provide your current address, telephone number, and employer information to the Division of Workers' Compensation and the insurance carrier.

7. You have the responsibility to tell the Division of Workers' Compensation and the insurance carrier any time there is a change in your employment status or wages. Examples include:

- **You stop working because of your injury;**
- **You start working; or**
- **You are offered a job.**

AVISO SOBRE LOS DERECHOS Y RESPONSABILIDADES PARA LOS EMPLEADOS LESIONADOS EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES DE TEXAS

El Aviso sobre los Derechos y Responsabilidades para los Empleados Lesionados en el Sistema de Compensación para Trabajadores puede ser impreso en formato de PDF

Injured Employee Rights and Responsibilities in English

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

Para comunicarse con la Oficina de Asesoría Pública para el Empleado Lesionado llame gratis al 1-866-EZE-OIEC (1-866-393-6432). Para mayor información, visite el sitio Web www.oiec.state.tx.us.

Para comunicarse con la División de Compensación para Trabajadores llame gratis al 1-800-252-7031. Para mayor información sobre la División de Compensación para Trabajadores, visite el sitio Web http://www.tdi.state.tx.us/wc/indexwc.html.

SUS DERECHOS EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES DE TEXAS

1. Usted puede tener derecho a recibir beneficios.

Usted puede tener derecho a recibir beneficios sin importar quien tuvo la culpa de su lesión, con ciertas excepciones, tales como:

- Si se encontraba en estado de ebriedad en el momento que ocurrió la lesión;
- Si se lesionó usted mismo a propósito o cuando estaba tratando de lesionar a otra persona;
- Si su lesión fue causada por otra persona por razones personales;
- Si resultó lesionado por un acto de Dios;
- Si su lesión ocurrió por estar jugueteando; o
- Si su lesión ocurrió cuando usted voluntariamente participaba en una actividad fuera de su empleo.

2. Usted tiene derecho a recibir atención médica para atender la lesión o enfermedad relacionada con su trabajo. No existe un marco de tiempo límite para recibir la atención médica.

3. Usted tiene derecho a escoger a su médico tratante. Si pertenece a una Red de Servicios Médicos de Compensación para Trabajadores – red - (Workers' Compensation Health Care Network, por su nombre en inglés) usted puede escoger a su médico de la lista de médicos tratantes en la red. Si no pertenece a una red, usted puede escoger a un médico de la Lista de Médicos Aprobados. Esta lista es actualizada por la División de Compensación para Trabajadores.

Es importante que usted siga todos los reglamentos del sistema de compensación para trabajadores. Si no sigue estos reglamentos, usted podría ser responsable por el pago de las cuentas médicas.

4. Usted tiene derecho a contratar a un abogado en cualquier momento para que lo ayude con su reclamo.

5. Usted tiene derecho a recibir información y ayuda gratuita por parte de la Oficina de Asesoría Pública para el Empleado Lesionado.

El personal de OIEC está a su disposición para contestar sus preguntas y explicar sus derechos y responsabilidades. Llame gratis al 1-866-EZE-OIEC (1-866-393-6432).

6. Usted tiene derecho a recibir ayuda por parte de un ombudsman si no cuenta con un abogado, en caso que se haya programado un procedimiento de resolución de disputas.

Un ombudsman es un empleado de la Oficina de Asesoría Pública para el Empleado Lesionado. Los ombudsman están entrenados en las funciones de compensación para trabajadores y proporcionan asistencia gratuita a los empleados lesionados que no cuentan con la representación de un abogado. Un ombudsman no puede firmar documentos en nombre suyo, tomar decisiones por usted o proporcionar asesoramiento legal. Los procedimientos referentes a su reclamo pueden incluir conferencias para revisión de beneficios (benefit review conference – BRC, por su nombre y siglas en inglés), o audiencias para disputar beneficios (contested case hearing – CCH, por su nombre y siglas en inglés). Los procedimientos son llevados a cabo en las oficinas locales y por lo menos un ombudsman está disponible en cada oficina local.

7. Usted tiene derecho a que la información sobre su reclamo se mantenga confidencial.

En la mayoría de los casos, el contenido del expediente de su reclamo no puede ser obtenido por otros. Algunos participantes del caso, tales como su empleador o la compañía de seguros de su empleador tienen derecho a saber lo que contiene el expediente de su reclamo. También, puede ser que

un empleador que está considerando contratarlo pueda obtener información limitada sobre su reclamo de la División de Compensación para Trabajadores.

SUS RESPONSABILIDADES EN EL SISTEMA DE COMPENSACIÓN PARA TRABAJADORES DE TEXAS

1. Usted tiene la responsabilidad de avisar a su empleador si se ha lesionado en el curso y amplitud de su empleo.

Usted debe informar a su empleador dentro de 30 días a partir de la fecha en que sucedió su lesión o a partir de la fecha en que supo que la lesión o enfermedad estaba relacionada con su trabajo.

2. Usted tiene la responsabilidad de saber si pertenece a una red de servicios médicos de compensación para trabajadores (red).

Si no sabe si usted pertenece a una red, pregunte al empleador para quien estaba trabajando al momento en que sufrió la lesión. Si pertenece a una red, usted tiene la responsabilidad de seguir los reglamentos de dicha red. Su empleador debe darle una copia de los reglamentos del Departamento de Seguros de Texas con respecto a las redes. Lea los reglamentos cuidadosamente. Si hay algo que no entiende pregunte a su empleador o llame a la Oficina de Asesoría Pública para el Empleado Lesionado. Si desea presentar una queja contra la red, llame a la Línea de Ayuda al Consumidor al 1-800-252-3439 o presente su queja electrónicamente en http://www.tdi.state.tx.us/consumer/complfrm.html

3. Usted tiene la responsabilidad de informar a su médico como fue que sufrió la lesión y si la lesión está o no relacionada con su trabajo.

4. Usted tiene la responsabilidad de llenar y enviar el formulario de reclamo (DWC-41) a la División de Compensación para Trabajadores. Usted cuenta con un año para enviar este formulario a partir de la fecha en que usted se lesionó o a partir de la fecha en que supo que su enfermedad estaba relacionada con su trabajo.

Llene y envíe el formulario DWC-41 aún si usted ya está recibiendo beneficios. Usted podría perder su derecho para recibir beneficios si no envía el formulario a la División de Compensación para Trabajadores. Para pedir una copia del formulario DWC-41 llame al 1-800-252-7031 o al 1-866-393-6432.

5. Usted tiene la responsabilidad de proporcionar a la División de Compensación para Trabajadores y a la compañía aseguradora su domicilio actual, número de teléfono y la información sobre su empleador.

6. Usted tiene la responsabilidad de avisar a la División de Compensación para Trabajadores y a la compañía aseguradora cada vez que haya un cambio en el estado de su empleo o salario. Algunos ejemplos:

- si deja de trabajar debido a su lesión;
- comienza a trabajar; o
- le ofrecen un trabajo.

NOTICE TO EMPLOYEES CONCERNING ASSISTANCE AVAILABLE IN THE WORKERS' COMPENSATION SYSTEM FROM THE OFFICE OF INJURED EMPLOYEE COUNSEL

Have you been injured on the job? As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is the state agency that assists unrepresented injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-393-6432. More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.texas.gov).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN? An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

An Ombudsman can help you identify and develop the disputed issues in your case and attempt to resolve them. If the issues cannot be resolved, the Ombudsman can help you request a dispute resolution proceeding at the Texas Department of Insurance, Division of Workers' Compensation. Once a proceeding is scheduled an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
- Attend the proceeding with you and communicate on your behalf; and
- Assist you with an appeal or a response to an insurance carrier's appeal, if necessary.