TDI Division of Workers' Compensation

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

Complete if known:

DWC claim #

Insurance carrier claim #

Employer's report for reimbursement of voluntary payment

Part 1: Injured employee Information

1. Name (first, middle, last)	**2. Address** (street or PO box, city, state, ZIP code)
3. Social Security number (last four digits) XXX-XX-	**4. Date of injury** (mm/dd/yyyy)

Part 2: Employer information

5. Name		**6. Address** (street or PO box, city, state, ZIP code)
7. Phone number	**8. Email address**	**9. Federal employer identification number** (FEIN)
10. Name of person submitting form		**11. Job title** (of person submitting form)
12. First day employee was absent from work (mm/dd/yyyy)		**13. Date of first payment** (mm/dd/yyyy)
14. Amount of payment $		**15. Number of weeks paid**

16. Payment period from (mm/dd/yyyy) **to** (mm/dd/yyyy)

17. This payment:

☐ Begins compensation ☐ Covers medical expenses

☐ Supplements injured employee's income

Employee's name:

DWC claim number:

For DWC use only

Part 3: Insurance carrier information

18. Name		**19. Address** (street or PO box, city, state, ZIP code)
20. Phone number	**21. Email address**	**22. FEIN**
23. Insurance carrier representative		**24. Address of insurance carrier claims office** (street or PO box, city, state, ZIP code)

Part 4: Certification

23. Certify with your signature:

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

Signature_____ **Date**_____

Employee's name:

DWC claim number:

For DWC use only

FAQ

Employer's report for reimbursement of voluntary payment

Where do I send this form?
Send a copy of this form to the Texas Department of Insurance, Division of Workers' Compensation (DWC) and the insurance carrier. You can fax or mail the completed form to DWC or drop the form off at a DWC field office.

- **Fax:** 512-804-4301
- **Mail:** Texas Department of Insurance, Division of Workers' Compensation
  Business Process, MS BP-OPS
  PO Box 12050
  Austin, Texas 78711-2050

When do I send this form to DWC and the insurance carrier?
Send the form within seven days after the date of first payment. An employer should also timely file the DWC Form-001, *Employer's First report of injury or illness* as Texas Labor Code Section 409.005 requires. If you fail to do this, it will waive your right to reimbursement of any voluntary payments.

When do I get paid?
The insurance carrier should reimburse the employer within seven days after receiving the request. The insurance carrier should notify DWC within seven days of reimbursing the employer the amount reimbursed and the date of the reimbursement.

What happens if the insurance carrier refuses to reimburse me?
If there is a dispute concerning reimbursement, the employer may file a subclaim in accordance with Labor Code Section 409.009.

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.