Division of Workers' Compensation

Subsequent Injury Fund Reimbursement Request Form – Multiple Employment

I. SUBSEQUENT INJURY FUND (SIF) REQUEST INFORMATION

1. Reimbursement Amount Requested	2. Request Date
3. Contact Name	
4. Contact Phone Number	5. Contact Email Address

II. CLAIM INFORMATION

6. Injured Employee's Name (First, Middle, Last)	
7. Employee's Date of Injury	8. DWC Claim Number

III. PAYEE (Insurance carrier)

9. Name of Payee	10. Payee Federal Tax ID No.
11. Address of Payee (Street or P.O. Box, City, State, ZIP Code)	

IV. TELL US ABOUT THE REASON FOR SEEKING THIS REIMBURSEMENT

12. Claim Employer Name	13. Average Weekly Wage	14. Weekly Benefit Rate
15. Non-Claim Employer Name	16. Average Weekly Wage (non-claim employment only)	
17. Combined Average Weekly Wage (items 13 + 16)	18. Combined Weekly Benefit	
19. Post Injury Earnings (PIE) Amount (if any)	20. PIE Employer Name (if any)	
21. Benefit Period for This Request		
22. Benefit Periods of Previous Requests (if any)	23. Previously Reimbursed Amounts (if any)	

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V. TELL US ABOUT THE TOTAL AMOUNT OF REIMBURSEMENT REQUESTED

24. Type of Benefits (check all that apply)

☐ Temporary Income Benefits ☐ Impairment Income Benefits ☐ Supplemental Income Benefits ☐ Lifetime Income Benefits ☐ Death Benefits

25. For each type of benefit requested state:

- the benefit period;
- total amount paid; and
- calculation of reimbursement requested.

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VI. REQUIRED ATTACHMENTS:

Include the following documents with each request:

- ☐ Wage statement signed and completed by claim employer (DWC Form-003 or DWC Form-003SD) or other supporting documentation for the average weekly wage.
- ☐ Wage statement signed and completed by the injured employee and non-claim employer (DWC Form-003ME).
- ☐ A detailed payment record for all income benefits paid that includes the following:
  - date of payment;
  - amount of payment;
  - type of benefit paid;
  - payee; and
  - benefit period.
- ☐ Complete documentation of weekly post injury earnings for each employer during the reimbursement period. Include documentation on any salary continuation.
- ☐ All plain language notices about the payment of income benefits.
- ☐ W-9 for the insurance carrier or authorized payee for any reimbursement that may be due.

Unless otherwise requested, please limit submission to the above items.

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Frequently Asked Questions

Who can file DWC-Form-097?
Insurance carriers and their authorized representatives should use this form to submit the insurance carrier's request for reimbursement from SIF for benefits paid from multiple employment.

Can I use this form to submit a request for reimbursement?
Use the form appropriate to the cause of the reimbursable payment. DWC Form-097 should be used when the insurance carrier made benefit payments attributed to multiple employment. Insurance carriers are entitled to annual reimbursement for the amount of income or death benefits paid to an employee that are based on employment other than the employment during which the compensable injury occurred.

When can I file DWC-Form-097?
Requests for reimbursement for increased benefits due to an injured employee's multiple employment must be filed the same or following fiscal year that the benefits are paid. A fiscal year begins each September 1 and ends on August 31 of the next calendar year. For example, if benefits are paid during the fiscal year from September 1, 2020, through August 31, 2021, the request for reimbursement must be submitted by August 31, 2022.

What statutes and rules apply to this type of reimbursement?
Texas Labor Code Sections 403.006(b)(3) and 408.042(g) and 28 Texas Administrative Code Section 116.11(a)(3) and (e).

What response do you expect for question 12?
The claim employer is the name of your insured.

What response do you expect for question 13?
List the injured employee's average weekly wage (AWW) for the claim employer.

Note that for some claims, more than one AWW may apply over the benefit payment period. Please list and label each. For example, if an injured employee was provided non-pecuniary benefits for only part of the benefit period, provide the AWW with and without non-pecuniary benefits. Likewise, school districts use a different calculation method to calculate AWW.

What response do you expect for question 14?
Calculate the weekly benefit rates based on the AWW for the claim employer only. Include the impact of post injury earnings from the claim employer, as well as any statutory maximum and minimum benefit amounts.

If the injured employee's weekly benefit rate changed over the reimbursement period due to post injury earnings or changes in non-pecuniary wages, list and label each rate that applies.

What response do you expect for question 15?
Provide information based on the employment other than the employment during which the compensable injury occurred. If there is more than one, list each.

What response do you expect for question 16?
List the injured employee's AWW for the non-claim employer. If there is more than one, list each.

What response do you expect for question 17?
List the AWW based on all employment used to calculate the benefit rate. If there is more than one, list each.

What response do you expect for question 18?
List the benefit rate based on all employment. Include the impact of post injury earnings from the claim employer as well as any statutory maximum and minimum benefit amounts. If more than one applies, list each. For example, list both the temporary income benefit (TIB) and impairment income benefit (IIB) rate if both applied. Likewise, if the injured employee's weekly benefit rate changed over the reimbursement period due to post injury earnings or changes in non-pecuniary wages, list and label each rate that applies.

What response do you expect for question 19?
Did the injured employee have any post injury earnings, including salary continuation, during the benefit period? **If yes**, list the weekly post injury earnings and the period it was earned. If it varied by week and more space is needed, include the information in an attachment. **If no**, specify "none" and skip question 20.

What response do you expect for question 20?
Clarify the source of the post injury earnings, if any.

What response do you expect for question 21?
For ongoing claims, reimbursement requests should be submitted annually. Please clarify what benefit period this request includes or specify entire claim if this is the only reimbursement anticipated on this claim.

What response do you expect for question 22?
If a request was submitted for a different benefit period, specify which benefit period was included in the previous requests. If this is the first or only request on this claim, specify "N/A" and skip question 23.

What response do you expect for question 23?
How much was reimbursed on requests for previous benefit periods?

On question 24, if a payment was made as a temporary income benefit, then later credited as an impairment income benefit, which box do I check?
Multiple employment benefits should be requested for reimbursement based on how they are owed.

What response do you expect for question 25?
Provide a separate statement for any TIBs, IIBs, supplemental income benefits, lifetime income benefits, or death benefits requested.

- The benefit period is the period benefits are owed.
- Total amount paid should be the total from pay records, including any converted payments, overpayments, or payments made in error, if any.
- The calculation of reimbursement should show how you arrived at the amount requested.

Examples:

IIBs for 2/13/2018 to 3/5/2018 (three weeks).
Paid $420 per week for a total of $1,260.
Without multiple employment, we would have owed $250 per week for a total of $750.
We request a reimbursement of $510 ($1,260 - $750).

OR

TIBs for 1/1/2017 to 3/11/2017 (10 weeks).
We paid $3,370.
Owed $337 per week including all employment, but would have owed only $137, the minimum, without multiple employment. $200 per week is attributed to non-claim employment.
We request $200 x 10 weeks = $2,000.

For claims that have extensive benefit changes due to fluctuating post injury earnings, please provide a spreadsheet showing weekly calculations.

How do I submit this request?

- Electronic file transfer—If you already have an account with DWC, you may use the same electronic file transfer account. If you need an account, please contact our office at eFiling-Help@tdi.texas.gov; or
- Fax to 512-804-4759.

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 refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html