Send to:
Injured Employee
DWC Field Office Handling Claim

CLAIM# ______________________________

CARRIER'S CLAIM # ______________________________

NOTICE TO EMPLOYEE: INTENTION TO REQUEST DIVISION PERMISSION TO ADJUST BENEFITS (DWC Form-054)

Instructions for Insurance Carrier: The insurance carrier must obtain approval from the Texas Department of Insurance, Division of Workers' Compensation before an injured seasonal employee's temporary income benefits are adjusted because of a seasonal change in wages. When Division approval is requested for an adjustment, the injured employee must be informed of the intent by mailing by first class mail this notice to the employee.

1. Employee's Name (Last, First M.I.) and Telephone Number ( )	2. Social Security Number	3. Date of Injury
4. Mailing Address (Street or P.O. Box)	5. Employer's Business Name	
City State ZIP Code	6. Insurance Carrier's Name	

!!! NOTICE TO EMPLOYEE !!!

______________________________ the workers' compensation insurance carrier in the above styled
name of carrier
claim, intends to request approval from the Texas Department of Insurance, Division of Workers' Compensation to ☐ decrease ☐ increase your weekly temporary income benefit payment to $___________ because of a seasonal change in your wages. The proposed effective date of this change in your weekly payment is $ _____________.

You must submit to the insurance carrier's adjuster at the address shown below any available wage information within two (2) weeks from the date of this notice which is ___________________. The information may include wage records from the Texas Workforce Commission, copies of your W-2 forms, copies of bank statements, affidavits from your employer(s), payroll check stubs, or other documents showing your wages during previous years. Failure to submit the information may result in your weekly temporary income benefit being decreased based on your wage history for the most recent five (5) quarters available from the Texas Workforce Commission.

You have the right to request a Benefit Review Conference to resolve a dispute concerning a seasonal change in your wages. If you have any questions or need assistance, you can reach the Texas Department of Insurance, Division of Workers' Compensation at its toll-free number 1-800-252-7031 or contact the Division field office handling your claim.

7. Adjuster's Name (PRINTED)	8. Adjuster's Business Mailing Address
9. Adjuster's Telephone Number ( )	City State ZIP Code

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.