

TEXAS WORKERS' COMPENSATION **Education Conference**



EMPLOYER'S RIGHTS & RESPONSIBILITIES



Who is

CLAIMS AND CUSTOMER SERVICES?



Who is Claims and Customer Services?



To provide customer service by maintaining a knowledgeable workforce who promotes communication and educates system participants.

How to contact us...

Call:

1-800-252-7031

Go online:

www.tdi.texas.gov

Mail to:

**7551 Metro Center Drive
#100**

Austin, TX 78744

Who am I?



Kelly Little

*Employee Development
Specialist*

How to contact us...

Call:

1-800-252-7031

Go online:

www.tdi.texas.gov

Mail to:

**7551 Metro Center Drive
#100**

Austin, TX 78744

Where to find us...



Over 60 agents statewide ready to assist you

- Phone
- In person

How to contact us...

Call:

1-800-252-7031

Go online:

www.tdi.texas.gov

Mail to:

**7551 Metro Center Drive
#100**

Austin, TX 78744

We provide customer service



- English and Spanish speaking agents

How to contact us...

Call:

1-800-252-7031

Go online:

www.tdi.texas.gov

Mail to:

**7551 Metro Center Drive
#100**

Austin, TX 78744

We promote communication



- Injured employees
- Insurance carriers
- Health care providers
- Employers

How to contact us...

Call:

1-800-252-7031

Go online:

www.tdi.texas.gov

Mail to:

**7551 Metro Center Drive
#100**

Austin, TX 78744

We educate



- Field office education sessions
- Annual education conferences

How to contact us...

Call:

1-800-252-7031

Go online:

www.tdi.texas.gov

Mail to:

**7551 Metro Center Drive
#100**

Austin, TX 78744

We offer informal dispute resolution



- Gather documentation
- Share information

What are the

EMPLOYER'S RIGHTS?

RIGHT TO: Contest the compensability of a claim if the insurance carrier accepts liability for payment of benefits.

- If the insurance carrier accepts that the injury or illness is work-related and pays benefits, the employer can dispute the carrier's determination.
- File DWC Form-004, *Employer's Contest of Compensability*, or DWC Form-045, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference*.

RIGHT TO: Be notified of a proposal to settle a claim or of any administrative or judicial proceeding related to resolution of a claim.

- As an employer, you must send a written request to be notified of any settlements.
- You will receive a notice for every scheduled proceeding.
- Your attendance is not required, unless you are the requesting party.
- If you have information or documents that may help in resolving the dispute, you may present them at the proceeding.

RIGHT TO: Report suspected fraud to the Division or to the insurance carrier.

Calling the consumer help line at:

1-800-252-3439

Filing the online form at

www.tdi.texas.gov

Email:

FraudReport@tdi.texas.gov

Fax:

512-490-1001

Mail:

**TDI Fraud Unit MC
109-3A
PO Box 149336
Austin, TX 78714-9336**

RIGHT TO: Contest the failure of the insurance carrier to provide required accident prevention services.

- Per Texas Labor Code §411.061 and §411.068(a)(1), an insurance company writing workers' compensation insurance in Texas is required to provide, and maintain adequate accident prevention services to meet the business nature of the employer the policy covers.
- For more information about accident prevention services requirements, contact us by phone **512-804-4626** or email aps@tdi.texas.gov.

RIGHT TO: Receive return-to-work coordination services as necessary to facilitate an employee's return to employment.

- To help employers develop their own return to work procedures, the TDI-DWC offers individual consultations, workshops, seminars, training, and an employer resource guide.
- For more information about effective return-to-work practices for employers, contact us by phone **512-804-4804** or email Pat.Crawford@tdi.texas.gov.

What are the

EMPLOYER'S RESPONSIBILITIES?

SHALL: Report any work-related injuries, fatalities, and illnesses to your insurance carrier.

How many days to report a fatality?

No later than 8th day of knowing

How many days to report an illness?

No later than 8th day of knowing

How many days to report an injury?

No later than 8th day of employee missing 1+ day of work

SHALL: Report injury using DWC Form-001, *First Report of Injury or Illness*, and provide a copy to the employee, along with *Employee's Rights and Responsibilities*.

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.

1. Name (Last, First, MI.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>		15. Date of Injury (m-d-y)		16. Time of Injury am <input type="checkbox"/> pm <input type="checkbox"/>		17. Date Last 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? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>									
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>		21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*			
9. Mailing Address Street or P.O. Box City State Zip Code County									
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>									
11. Number of Dependent Children		12. Spouse's Name							
13. Doctor's Name									
14. Doctor's Mailing Address (Street or P.O. Box) City State Zip Code									
20. How and Why Injury/Illness Occurred*									
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box City State Zip Code									
24. Cause of Injury (fall, tool, machine, etc.)*									
25. List Witnesses									
26. Return to work date or expected (m-d-y)		27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. Supervisor's Name		29. Date Reported (m-d-y)			



OFFICE OF INJURED EMPLOYEE COUNSEL

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 1-800252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

- 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.
- 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 OIEC's website. You may also receive assistance from your employer's insurance carrier.

EMPLOYER'S
RESPONSIBILITIES

SHALL: File wage statements and supplemental reports of injury.

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 (AWWW) 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 file in the manner prescribed:
 (1) The wage statement to the carrier, the claimant or the claimant's representative, if any, of the earliest of:
 (A) the employer's date of injury
 (B) the date the employee received income benefits
 (C) the date of the employer's last payment of wages
 (2) The wage statement to the carrier, the claimant or the claimant's representative, if any, of the earliest of:
 (A) the employer's date of injury
 (B) the date the employee received income benefits
 (C) the date of the employer's last payment of wages
 (3) A subsequent wage statement and the employer's information if the employer discloses information after the date of the employer's last payment of wages.
 All applicable DW

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:
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number:	Federal Tax I.D. Number:

How many days to file wage statement?

Within 30 days of Temporary Income Benefits eligibility, or fatality

CLAIM # _____
 Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
3. Employer mailing address	
4. Insurance carrier name	
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes <input type="checkbox"/> no <input type="checkbox"/> If so, identify contact person and phone # _____	
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
7. Has the employer requested RTW training from DWC or the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes <input type="checkbox"/> Date _____ no <input type="checkbox"/>	
9. Has the employer requested accident prevention services from the insurance carrier? yes <input type="checkbox"/> no <input type="checkbox"/>	

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
 b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
 c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
 d. The injured worker resigned or was terminated from employment. File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN (last 4 digits)	13. DOB
14. Injured worker mailing address and phone	XXXX-XX	

How many days to file supplemental report?

10 days from change in pay or end of employment; 3 days from loss of time

MUST: Employers must take all actions reasonably necessary to ensure a safe workplace and take all steps reasonable necessary to protect the life, health and safety of the employees.

- Workplace Safety Programs
- Free Safety and Health Publications
- DVD and Audiovisual library
- OSHA 10-Hour Construction Course
- OSHCON
- Safety Violations Hotline

For Training:

SafetyTraining@tdi.texas.gov

512-804-4610

For Resources:

ResourceCenter@tdi.texas.gov

512-804-4620

SHALL: Comply with all appropriate statutes and rules of the Texas Labor Code, Texas Insurance Code, and Texas Administrative Code

- Employers that fail to comply with workers' compensation requirements commit an administrative violation and may be subject to administrative penalties.
- If you have any questions regarding reporting requirements or compliance with the law, contact us **1-800-252-7031**.

SHALL: Provide employees with information on their workers' compensation insurance coverage status, and must use Notice 6.

- Available in English and Spanish.
- Displayed in the employer's personnel office.
- Located where each employee is likely to see the notice on a regular basis.
- Printed in specific sized font.
- Contain the exact words as prescribed in 28 Texas Administrative Code (TAC) §110.101(e)(1).

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.

Notice 6 (01/13)

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

Rule 110.101(e)(1)

Any questions?

Contact us: **1-800-252-7031**