



Complete if known:

DWC claim #

Insurance carrier claim #

## Request for a lump sum payment of impairment income benefits (IIBs)

Este formulario está disponible en español en el sitio web de la División en

[www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html).

Para obtener asistencia en español, llame a la División al 800-252-7031.

**Filing instructions:** Fill out Section 1 and send it to the insurance carrier. See FAQ page for details.

### Section 1: Claim information

#### Part 1: Employee and insurance carrier information

<b>1. Employee's name</b> (first, middle, last)		<b>2. Date of injury</b> (mm/dd/yyyy)	
<b>3. Employee's mailing address</b> (street or PO box, city, state, ZIP code)		<b>4. Social Security number</b> XXX-XX-	
<b>5. Employer</b> (at time of injury)		<b>6. Employee's phone number</b>	
<b>7. Insurance carrier's name</b>		<b>8. Adjuster's name</b>	
<b>9. Adjuster's phone number</b>		<b>10. Adjuster's fax number</b>	

#### Part 2: Benefit information

<b>11. Name of the certifying doctor</b>			
<b>12. Maximum medical improvement date</b> (mm/dd/yyyy)		<b>13. Impairment rating</b> %	
<b>14. Date returned to work</b> (mm/dd/yyyy)		<b>15. Amount of weekly IIBs you're receiving</b> \$	
<b>16. Current pay rate</b> \$		<input type="checkbox"/> hourly <input type="checkbox"/> weekly <input type="checkbox"/> monthly <input type="checkbox"/> other	

Employee's name:  
DWC claim number:


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**17. Certify with your signature:**

- I understand that if my impairment rating is 15% or greater, I may be eligible for supplemental income benefits.
- I understand that if I receive a lump sum payment, I will not be entitled to supplemental income and lifetime income benefits for this claim.
- I certify that I have read and understand this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Section 2: Insurance carrier's decision**

**Carrier's filing instructions:** Send a copy of the decision to the Division of Workers' Compensation (DWC).

**18. Date request received** (mm/dd/yyyy)

**Approved**

We have approved your request for a lump sum and your payment will be issued.

**Denied** – Mark the reason for denial.

- You are earning less than 80% of preinjury average weekly wage
- You have not been back at work for 3 months
- Your impairment rating is being disputed
- Other

**19. Carrier representative's printed name**

**20. Signature**

**21. Date**

Employee's name:  
DWC claim number:



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## FAQ

### Request for a lump sum payment of impairment income benefits (IIBs)

#### Who can file the DWC Form-051?

The injured employee can file the DWC Form-051 to request a lump sum for IIBs when they have returned to work for at least three months and are earning at least 80% of their average weekly wage.

#### Where does the injured employee send this form?

Send your DWC Form-051 to the insurance carrier. Contact your insurance carrier adjuster for mailing address, fax number, or email address.

#### What will the insurance carrier do?

The insurance carrier will review the request and approve or deny within 14 days of receiving the DWC Form-051. They will send copies of the approval or denial to the injured employee, their representative, and DWC. If approved, the insurance carrier will include the payment to the employee. If denied, the injured employee can request a benefit review conference to dispute the insurance carrier's decision. The injured employee can get help by hiring an attorney or by contacting the Office of Injured Employee Counsel at 866-393-6432.

#### How does the insurance carrier send the approval or denial to DWC?

- **Fax:** 512-804-4378
- **Mail:** Texas Department of Insurance, Division of Workers' Compensation  
Claims and Customer Services, Mail Code CCS  
PO Box 12050  
Austin, TX 78711-2050

#### Questions?

Call 1-800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.

Go to [www.tdi.texas.gov/wc](http://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); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact [DWCLegalServices@tdi.texas.gov](mailto:DWCLegalServices@tdi.texas.gov) or go to the Corrections Procedure section at [www.tdi.texas.gov](http://www.tdi.texas.gov).