TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation (MS-94)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(800) 252-7031 | F: (512) 804-4378 | TDI.texas.gov | @TexasTDI

DWC CLAIM#

CARRIER CLAIM #

Send completed form to the DWC field office handling the claim and to the injured employee.

REQUEST TO ADJUST AVERAGE WEEKLY WAGE FOR SEASONAL EMPLOYEE

Instructions for Insurance Carrier: The insurance carrier's records show that the employee in the claim shown below has failed to furnish the wage information requested on _____. _____ now requests the
DATE CARRIER

Division's approval to adjust the injured seasonal employee's average weekly wage from $_____ to $_____ beginning _____ and ending on _____ . Attach _____
DATE DATE TYPE OF EVIDENCE

showing the employee's earnings during the same period in previous years.

A copy of this request must be provided to the injured worker at the same time it is submitted to the Division's field office handling the claim. Date mailed to Division and Employee: _____

1. Employee's Name (Last, First M.I.)	**2. Telephone 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 • • •

A representative of the Division will attempt to contact you upon the Division's receipt of the insurance carrier's Request to Adjust Average Weekly Wage for Seasonal Employee to explain the purpose of this request and to determine whether you agree with the request to adjust your average weekly wage and your weekly temporary income benefit payment.

Within the next 2 weeks you may request a Benefit Review Conference if you do not agree with the request for adjustment. Your dispute will be set for a Benefit Review Conference within 20 days of your request. You can give additional wage information for consideration. However, if you do not request a Benefit Review Conference within this period, the Division will approve the request for adjustment based on the wage information available.

If you have any questions or need help, call the Texas Department of Insurance, Division of Workers' Compensation at 1-800-252-7031 or contact the Division field office handling your claim.

FOR DIVISION USE

The insurance carrier's Request to Adjust Average Weekly Wage for Seasonal Employee in the above styled claim is:

☐ **APPROVED** Employee failed to request a Benefit Review Conference within the required 2-week period set forth above.

The average weekly wage is adjusted to $_____, and the temporary income benefit weekly payment is adjusted to $_____, beginning _____ and ending _____.

☐ **NOT APPROVED.** Reason: _____

Authorized DWC Employee Signature	Division Field Office Phone Number ( )
Division Field Office Address	City State ZIP Code

NOTE: With few exceptions, upon your request, you are entitled to be informed about the information TDI-DWC collects about you; get and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004). For more information, contact agencycounsel@tdi.texas.gov or you may refer to the Corrections Procedure section at www.tdi.texas.gov.