TDI Division of Workers' Compensation
PO Box 12050
Austin, TX, 78711
800-252-7031
tdi.texas.gov/wc

**Accident prevention services annual report**

**For calendar year** (yyyy)

## Part 1: Insurance company information

|  |  |
| --- | --- |
| **1. Insurance company name** | **2. Group name** (if applicable) |
| **3. Primary Texas loss control contact name** | **4. Contact phone number** |
| **5. Contact mailing address** (street or PO box, city, state, ZIP code) | **6. Contact email** |
| **7. Total number of workers’ compensation policies in effect as of December 31 of the report year.** | |

## Part 2: Accident prevention services information

|  |  |  |  |
| --- | --- | --- | --- |
| **8. Provide the number of policies in the following premium groups that received any type of workers’ compensation accident prevention services.** | | | |
| **a. Less than $25,000** | **b. $25,000-$100,000** | | **c. More than $100,000** |
| **9. Total dollar amount the insurance company spent for accident prevention services for Texas workers’ compensation policyholders:** | | | |
| **10. Provide the following information about policyholder requests for accident prevention services.**  **a. Total number of requests**       **b. Number fulfilled** | | | |
| **11. Number of workers’ compensation accident prevention surveys performed:** | | **12. Total number of work-related fatalities policyholders incurred during the calendar year:** | |
| **13. Provide evidence of effectiveness and accomplishments of the insurance company’s accident prevention services:** | | | |
| **14. List the services that use contractors.** | | | |

## Part 3: Insurance company certification

|  |  |
| --- | --- |
| **15. Insurance company’s authorized representative’s printed name** | **16. Phone number** |
| **17. Insurance company’s authorized representative’s title** | **18. Email** |
| **19.  By checking this box, I certify that the information in this report is correct and complete.** | **20. Date of certification** |

### FAQ

**Accident prevention services annual report**

**Who must file the DWC Form-109?**

An insurance company writing workers’ compensation insurance in Texas must file the DWC Form-109 with DWC as an annual report of its accident prevention services. Insurance companies must file the DWC Form-109 accurately and on time. A DWC Form-109 is considered filed with DWC only when it contains all required information.

**When do I file the initial DWC Form-109?**

An insurance company must file the DWC Form-109 as its **initial report** by the effective date of its first workers’ compensation policy:

* If it writes its first workers’ compensation insurance policy in Texas on or after September 1, 2013; or
* When it resumes writing workers’ compensation insurance in Texas and has not written workers’ compensation insurance with exposures in Texas for 12 or more months.

**When do I file the subsequent DWC Form-109?**

An insurance company must file each **subsequent** DWC Form-109 by April 1 of each year.

**How do I file the DWC Form-109?**

You must send the DWC Form-109 to [aps@tdi.texas.gov](mailto:aps@tdi.texas.gov).

**Are any fields on the DWC Form-109 optional?**

No, you must complete all applicable fields each time you file the DWC Form-109. For subsequent filings, some fields only require information that has changed since the last filing.

**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).
* 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 refer to the Corrections Procedure section at [www.tdi.texas.gov/commissioner/legal/lccorprc.html](http://www.tdi.texas.gov/commissioner/legal/lccorprc.html).