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 to the Division field office handling the claim.

CARRIER'S REQUEST FOR REDUCTION OF INCOME BENEFITS DUE TO CONTRIBUTION

Pursuant to Texas Workers' Compensation Act, Texas Labor Code, Section 408.084, at the request of the insurance carrier, the Division may order that impairment income benefits and supplemental income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries. The Division shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section. The insurance carrier has the sole responsibility of providing the documentation to support its request.

Box 1 through 10 to be completed by insurance carrier.

1. Employee's Name	2. Date of Injury	3. Employee's Telephone Number
4. Mailing Address (Street or P.O. Box)	5. Employer's Business Name	
City State ZIP	6. Insurance Carrier's Name	

7. The insurance carrier requests a Division Order to reduce the employee's impairment income benefits and supplemental income benefits by _____**%** for the effects of contribution from prior compensable injury(ies).

8. Prior compensable injury or injuries **(Note: Medical records documenting impairment must be attached to this request)**:

Claim Number (if applicable)	Date of Injury	Body Part(s) Involved	Impairment Rating (if applicable)

9. Impairment rating from current compensable injury ____% Body Part(s) Involved

10. Insurance Adjuster's Signature _____ Telephone Number ( )_____

Printed Name _____ Date _____

DIVISION ORDER

☐ **APPROVED** The insurance carrier is ordered to reduce impairment income benefits and supplemental income benefits (if any) by ____**%** for the effects of contribution.

☐ **DENIED** - For the following reason(s)

- ☐ Medical reports not attached (request may be resubmitted with documentation)
- ☐ Medical records do not support impairment from prior compensable injury
- ☐ Prior compensable injury's impairment was related to different body part or area
- ☐ No evidence of a prior compensable injury
- ☐ Cumulative impact of compensable injuries does not warrant reduction

Authorized DWC Employee's Signature _____ Telephone Number ( )_____

Printed Name and Title _____ Date _____

If the insurance carrier or the employee disagrees with the Division Order, he/she has the right to request a Benefit Review Conference.

DWC Form-033
(Carrier's Request for Reduction of Income Benefits Due to Contribution)

When a carrier requests to reduce an employee's income benefits because of the effects of contribution from prior compensable injuries, the carrier should use DWC Form-033, Carrier's Request for Reduction of Income Benefits Due to Contribution, and submit it to the Division field office handling the claim. Medical records documenting impairment related to the earlier compensable injury or injuries must be attached to DWC Form-033.

The Division will, after reviewing the documentation, approve or deny the request. If approved, the order will state the percentage by which impairment income benefits and supplemental income benefits, if any, can be reduced. If denied, the order will state the reason(s). A copy of the order will be sent to the carrier, the injured employee and the employee's representative, if any.

If the insurance carrier or the employee disagrees with the order, either party may request a Benefit Review Conference. The insurance carrier and the employee's representative, if any, are required to use DWC FORM-45, Request for a Benefit Review Conference. An unrepresented employee may request a conference by contacting the Division in any manner.

[Texas Workers' Compensation Act, Texas Labor Code, Section 408.084, Contributing Injury]

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.