Thank you for choosing Texas Mutual Insurance Company. We created this brief guide to help you get the most out of your *Texas Mutual®* coverage.

Understand your premium

We estimate your annual premium at the beginning of your policy by reviewing your payroll, the type of work your employees perform, your loss history, your safety programs and other factors. You must pay the full amount at the beginning of your policy year, unless you arrange for premium financing or your account qualifies for interim payroll reporting.

At the end of your policy period, we will review your account for changes in your payroll or operations during the policy year. We will then adjust your premium, if necessary. You may get money back, or you may be billed accordingly.

Report injuries

- Report injuries the same day they happen, if possible. The fastest way to report injuries is at www.texasmutual.com. If you cannot report online, you may report by phone at (800) 859-5995, or send a completed DWC-1 form by fax to (877) 404-7999 or by mail to Texas Mutual Insurance Company, P.O. Box 12029, Austin, Texas 78711-2029.
- Give the employee a copy of the injury report and the "Employee's Rights and Responsibilities" form.
- Keep accurate records of the dates when you take any claim-related action, including when you file a supplemental report (DWC-6 form) or wage statement (DWC-3 form). To file a DWC-3 form online, go to www.texasmutual.com, log into the Employer claim detail tool, look up the claim, and click Complete Online DWC-3 Form.
- If you have a network policy, give the employee a copy of the "Notice of Network Requirements." Have him or her sign the acknowledgment form, and keep the form for your records. The notice and acknowledgment form are available in the Health Care Network section at www.texasmutual.com.

Prevent workplace accidents

A solid workplace safety program contributes to improved productivity and lower workers' compensation costs. Visit the free safety resource center at www.texasmutual.com to learn how to prevent accidents.

[over...]

Launch a return-to-work process

When an employee misses work due to on-the-job injuries, their employer must find a way to make up for lost production. Meanwhile, the injured employee must contend with the depression and financial stress that often come with being away from work. Texas Mutual will work with you to get your injured employees well and back on the job. Visit www.texasmutual.com/safety/rtwtools.shtm for more information and free tools.

Fight fraud

Workers' compensation fraud touches everyone in the form of higher premiums. Texas Mutual employs three teams of full-time fraud investigators. They need your help to stamp out fraud. Visit the Fighting Fraud section at www.texasmutual.com to learn your role.

Save time with *Texas Mutual®* online

You can handle most of your workers' comp needs at www.texasmutual.com. Visit our website to report injuries, get safety training materials, review claim detail reports, submit interim payroll reports and report suspected fraud.

Get telephone assistance

Use our enhanced automated phone services at (800) 859-5995 between 6:00 a.m. and 9:00 p.m. CST to:

- Verify quote and policy status, including issue date and policy period
- Check payment status, including amount and receipt date
- Retrieve return payment information, including check number and issue date
- Confirm deposit and/or annual premium amount due
- Verify claim number and assigned workers' compensation specialist
- Get address and fax information

Representatives are available between 8:00 a.m. and 5:30 p.m. CST to help with:

- Interim and final audit information
- Information and enrollment for free policyholder workshops
- Access to password-protected online services and password reset
- Workers' comp health care network information
- Any of your workers' comp needs

"*Texas Mutual®*" is a registered service mark of
Texas Mutual Insurance Company.
Visit our website at www.texasmutual.com.

51000-1007-0908

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 filling.

CLAIM # ____________________

CARRIER'S CLAIM # ____________________

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☐ M ☐
3. Social Security Number - -	4. Home Phone ( )
5. Date of Birth (m-d-y) - -	
6. Does the Employee Speak English? YES ☐ NO ☐	If No, Specify Language
7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box	
City State Zip Code County	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐	
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	

15. Date of Injury (m-d-y) - -	16. Time of Injury am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -
18. Nature of Injury*	19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*		
21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site		
Street or P.O. Box	County	
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 ☐ NO ☐	28. Supervisor's Name	29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months ____ Years ____	33. Length of Service in Occupation Months ____ Years ____
34. Employee Payroll Classification Code	35. Occupation of Injured Worker		
36. Rate of Pay at this Job $____Hourly $____Weekly	37. Full Work Week is ____ Hours ____ Days	38. Last Paycheck was: $____ for ___ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form	41. Name of Business
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )	43. Business Location (If different from mailing address) Number and Street
City State Zip Code	City State Zip Code

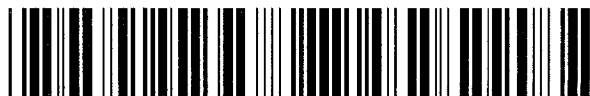
44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No
48. Workers' Compensation Insurance Company		49. Policy Number	

50. Did you request accident prevention services in past 12 months?

YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X ____________________ Date ____________________



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 ☐ no ☐
If so, identify contact person and phone # ______________________ ______________________

6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date __________ no ☐

7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐

8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date __________ no ☐

9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

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	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	

17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
If yes, the date of the 8th day (mm/dd/yyyy) ______________

18. Date of most recent RTW ________
☐ Full duty, full pay
☐ Limited duty, full pay
☐ Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
date of resignation ________ date of termination ________ date of death ________
19a. Reason for resignation/termination
____
19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐

20. Hours the injured worker was working during the pay period of
________ to ________ : ________ hours per week

Indicated hours are:
☐ Increase from pre-injury
☐ Same as pre-injury
☐ Decrease from pre-injury

21. Weekly/hourly earnings for the pay period of ________
to ________ : $ ________ weekly or $ ________

Indicated wages are:
☐ Increase from pre-injury wage
☐ Same a pre-injury wage
☐ Decrease from pre-injury wage

This form to be filed with: *The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.*

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

______________________________ ______________
Signature and Title of person completing this form Date