NonSubscriber – Compliance Package

We have enclosed the forms that are so vital in maintaining your status as a Non-Subscriber in the state of Texas. They include:

1. The DWC Form-005 (Rev. 02/18) that you must complete annually between February 1st and April 30th.
   Complete and send in to the state by Certified Mail, return receipt requested. You can now file your DWC Form 5 on-line: http://www.tdi.texas.gov/forms/dwc/dwc005nocov.pdf. Texas Department of Insurance is now requiring effective dates be listed in Section I; Question 1. Effective date must be May 1st of current year and expiration date April 30th of next year.

2. The DWC Form-7 that you need to complete to report any claims. Send in monthly, only if there were injuries that resulted in lost time in excess of the date of the injury.

3. The "Notice to Employees" that you must have all current employees sign. All employees must sign this form when they are hired and then placed in their personnel file.

4. The posters that are required to be posted "in an area frequented by the employees". The "Notice to Employees concerning Workers' Compensation in Texas" must be posted in both English and Spanish and any other appropriate language.

Texas Department of Insurance

FOR IMMEDIATE RELEASE – September 24, 2012

FOR MORE INFORMATION – Michelle Banks (512)804-4203 or (media) John Greeley (512)463-6425
pio@tdi.state.tx.us – http://www.tdi.texas.gov/wc/news/index.html

Texas Workers' Compensation Nonsubscriber Employers Reporting Requirements Change on January 1

AUSTIN, TX — Effective January 1, 2013, Texas employers who do not carry workers' compensation insurance coverage have new requirements for reporting their non-coverage status to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), the state agency responsible for regulating workers' compensation, and to their employees. In addition, they are required to report work-related injuries and occupational illnesses to the TDI-DWC. An employer's failure to comply with these notification requirements is an administrative violation and the employer may be subject to penalties [Texas Labor Code §406.004(a) and (e), §411.032(a) and (c), and Chapter 415, Subchapter C].

All employers in Texas that do not carry workers' compensation insurance and whose employees are not exempt from coverage under the Texas Workers' Compensation Act are required to notify the TDI-DWC by filing the recently revised DWC Form-005, *Employer Notice of No Coverage or Termination of Coverage.* For notices required to be submitted to the TDI-DWC on or after January 1, 2013, employers must file the DWC Form-005:

- annually between February 1st and April 30th of each calendar year as long as the employer remains in operation and does not have workers' compensation insurance coverage (covering a notice period of May 1st of the year of notice submission through April of the subsequent year);
- within 30 days of the employer hiring its first employee, unless this due date falls between February 1st and April 30th and the employer submits the notice within this time period; and
- within 10 days of receipt of a TDI-DWC request for filing a notice of no coverage.

An employer reporting **notice of termination of coverage** must file the DWC Form-005:

- within 10 days after notifying the insurance carrier of the termination of coverage unless the employer purchases a new policy or becomes a certified self-insurer; and
- annually thereafter, on the anniversary of the cancelation date of the workers' compensation policy as long as the employer remains in operation and does not have workers' compensation insurance coverage.

Employers will be required to file the revised DWC Form-005 with the TDI-DWC on and after January 1, 2013. Non-coverage status can be reported online on the TDI website at https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp under "Employer Online Filings."

Employers completing the DWC Form-005 online will be required to supply the business name, business type, Federal Employer Identification Number and details on business locations or updated information on business locations. Hard copies of the revised form are available for download from the TDI website. The DWC Form-205, *Locations of Employer's Business(es)*, is also available for download from the TDI website. This form is filed as an attachment to the DWC Form-005.

(more)

In addition to reporting non-coverage status to the TDI-DWC, employers are required to notify their employees that they do not carry workers' compensation insurance coverage. An employer must post the recently revised *Notice to Employees Concerning Workers' Compensation in Texas* in their workplace in English, Spanish and any other language common to the employer's employee population in the print type specified by TDI-DWC rules by January 1, 2013 and whenever the employer:

- elects to not have workers' compensation insurance;
- cancels or terminates workers' compensation insurance;
- withdraws from certified self-insurance; or
- has its workers' compensation coverage cancelled by the insurance company.

Employers must also provide a written copy of the recently revised *Notice to Employees Concerning Workers' Compensation in Texas* to each employee:

- at the time of hire;
- when the employer elects to not have workers' compensation insurance;
- within 15 days of notification to the insurance carrier that the employer is terminating workers' compensation insurance coverage unless the employer maintains continuous workers' compensation insurance coverage under a new policy or becomes a certified self-insurer; or
- within 15 days of cancellation of the employer's workers' compensation insurance coverage by the insurance company.

Texas employers with five or more employees who are exempt from workers' compensation coverage under Texas Labor Code §406.091 are also required to report work-related injuries and illnesses to the TDI-DWC. Employers must report each work-related injury or illness by the seventh day of the following month using the DWC Form-007, *Non-Covered Employer's Report of Occupational Injury and Illness*, for each:

- work-related injury resulting in the employee's absence from work for more than one day;
- occupational disease of which the employer has knowledge; and
- work-related fatality.

All employees are included under this requirement except domestic workers; casual workers engaged in employment incidental to a personal residence; certain farm and ranch workers; and employees covered by a method of compensation established under federal law.

Workers' compensation insurance coverage provides covered employees with income and medical benefits if they sustain a work-related injury or illness. Most Texas private employers can choose whether or not to provide workers' compensation insurance coverage for their employees. Except in cases of an intentional act or omission or gross negligence involving a fatality, workers' compensation insurance limits an employer's liability if an employee brings suit against the employer for damages.

Copies of the DWC Form-005, DWC Form-007, DWC Form-205 and *Notices to Employees Concerning Workers' Compensation in Texas* are available for download from the TDI website at www.tdi.texas.gov/forms/form20.html.

New and amended rules Texas Administrative Code §§160.1-160.3 as adopted by the Commissioner of Workers' Compensation may be viewed on the Secretary of State website at http://www.sos.state.tx.us/texreg/index.shtml.

If you have questions about employer workers' compensation reporting requirements, contact the TDI-DWC's Insurance Coverage section at 1-800-372-7713.

###

Texas Department of Insurance
Division of Workers' Compensation - Insurance Coverage (MS-96)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(800) 252-7031 | F: (512) 804-4146 | TDI.texas.gov | @TexasTDI

DWC005

Submit Form

Employer Notice of No Coverage or Termination of Coverage

La versión en español está disponible en http://www.tdi.texas.gov/forms/dwc/dwc005snocov.pdf

I. EFFECTIVE DATES (The effective dates cannot exceed a one-year period)

The election selected below is effective from ☐☐☐☐☐☐☐☐ (mm/dd/yyyy) to ☐☐☐☐☐☐☐☐ (mm/dd/yyyy).

II. STATEMENT OF NO COVERAGE

1. SELECT ONE

☐ The employer named below **DOES NOT HAVE** workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.004.

OR

☐ The employer named below **HAS TERMINATED** workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.007. (Provide the following information.)

Policy terminated effective (mm/dd/yyyy): ☐☐☐☐☐☐☐☐

Policy number:

Insurance company:

Insurer informed of termination on (mm/dd/yyyy): ☐☐☐☐☐☐☐☐

Employees were (or will be) notified on (mm/dd/yyyy): ☐☐☐☐☐☐☐☐

III. STATEMENT OF REPORTABLE INJURIES OR DISEASES

2. Did you have any death, injury that resulted in the injured employee's absence from work for more than one day, or knowledge of an occupational disease since your last *Employer Notice of No Coverage or Termination of Coverage*? ☐ Yes ☑ No

If your response is "Yes", you may be required to file a DWC Form-007, *Non-covered Employer's Report of Occupational Injury or Illness.* (See the Frequently Asked Questions section of this form.)

IV. PRIMARY EMPLOYER INFORMATION

3. Employer Business Name

4. Federal Employer ID Number ☐☐-☐☐☐☐☐☐☐

5. Employer Business Mailing Address (Street or PO Box, City State Zip)

T X ☐☐☐☐☐☐☐☐☐

6. Employer Business Type

7. Six-Digit NAICS Code ☐☐☐☐☐☐

NOTE: You must provide name, Federal Employer ID number and address of each Texas business location, subsidiary, or separate entity of the primary employer covered by this report.

Row	Name	Federal Employer ID Number	Address
Next Row Delete			Street or PO Box City / State / Zip Code

V. PERSON PROVIDING INFORMATION

8. Name

9. Telephone Number (area code, number, extension)

10. Title

11. E-mail Address

12. Signature

13. Date of Signature (mm/dd/yyyy) ☐☐☐☐☐☐☐☐

For TDI-DWC Use Only

Frequently Asked Questions
Employer Notice of No Coverage or Termination of Coverage

Who must file the DWC Form-005?

You must file the DWC Form-005 if you:

- do not have workers' compensation insurance, or
- you have terminated your workers' compensation insurance coverage

However, if your only employees are exempt from coverage under the Texas Workers' Compensation Act (for example, certain domestic workers, and certain farm and ranch workers) you do not have to file.

Failure to file the form when required may subject the employer to administrative penalties.

How do I file the DWC Form-005?

Employers can submit the DWC Form-005 to the TDI-DWC by:

- **filing electronically on the TDI website at:** https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp;
- faxing the form to (512) 804-4146; or
- mailing the form to the address listed at the top of the form.

When do I file the DWC Form-005?

You must file a separate DWC Form-005 each time one of the following conditions exists:

- **Annually** between February 1st and April 30th of each calendar year;
- **Within 30 Days** of hiring your first employee, unless this due date falls between February 1st and April 30th and you submit the form within this time period;
- **Within 10 Days** of receiving a request (to file the DWC Form-005) from DWC;
- **Within 10 Days** after notifying your workers' compensation insurance carrier that you are terminating coverage unless you purchase a new policy or become a certified self-insurer;

How do I determine my filing start date?

Use **May 1**, unless:

1. You have never filed a DWC Form-005, then the start date is the first day you did not have coverage (see either #2 or #3 to determine the specific date).
2. You terminated workers' compensation insurance coverage, then the start date is the first date you did not have coverage.
3. You hired your first employee, then the start date is the first day the employee started working.

How do I determine my filing period end date?

Use **April 30**, unless:

- You purchased, or plan to purchase a workers' compensation insurance policy, then the End Date is the last date you did not, or will not, have coverage.

What is a NAICS code?

NAICS (pronounced "nakes") is the six-digit North American Industry Classification System code that identifies the classification of your business. You may be able to locate the code in either:

1. Block 5 of your Unemployment Quarterly Report (Form C-3) from the Texas Workforce Commission; and/or;
2. If you have multiple NAICS codes, they may appear in the left margin of the Multiple Worksite Report - BLS 3020 from the U.S. Bureau of Labor Statistics; or
3. For more help with NAICS codes, visit the NAICS web page at:

www.naics.com

Select "Find Your NAICS Code" from the top menu and use the "NAICS Keyword Search" to enter one or more words that generally describe your business. For example, if you are in the restaurant business, enter "restaurant" and get a complete listing of NAICS codes for the restaurant industry.

Are any fields on the DWC Form-005 optional?

All applicable fields must be completed each time the DWC Form-005 is filed.

Section I
- The effective dates are always required.

Section II
- When reporting cancellation or termination of workers' compensation insurance in Statement of No Coverage, the policy and insurer information, and the notification dates must be provided.

Section III
- A selection from Statement of Reportable Injuries or Diseases is always required.

Section IV
- All primary employer fields (boxes 3 through 7) are required.
- Additional business location information is required when applicable.

Section V
- The signature field is not required when filing online.

How/when must a non-subscriber notify employees that workers' compensation coverage is not provided?

You must post the ***Notice to Employees Concerning Workers' Compensation in Texas*** in the workplace in English, Spanish and any other language common to the employer's employee population in the print type specified by DWC rules whenever you:

1. elect to not have workers' compensation insurance;
2. cancel or terminate workers' compensation insurance;
3. withdraw from certified self-insurance; or
4. have workers' compensation coverage cancelled by the insurance company.

You **must also provide** this notice to each employee:

1. at the time of hire;
2. when the employer elects to not have workers' compensation insurance;
3. within 15 days of notification to the insurance carrier that the employer is terminating coverage unless the employer maintains continuous coverage under a new policy or becomes a certified self-insurer; or
4. within 15 days of cancellation by the insurance company.

The required notice may be found on the TDI website at:
http://www.tdi.texas.gov/forms/dwc/notice5.pdf (English) and
http://www.tdi.texas.gov/forms/dwc/notice5s.pdf (Spanish)

Are non-covered employers required to file other forms with TDI-DWC?

You must report work-related injuries and diseases using the DWC Form-007, *Employer's Report of Non-covered Employee's Occupational Injury or Diseases* if:

1. You have five or more employees and do not have workers' compensation insurance; or
2. you have employee(s) that have waived workers' compensation insurance coverage, whether or not you have workers' compensation insurance.

You must file the form not later than the 7th day of the month following any month in which:

- a work-related death occurred;
- an employee was absent from work for more than one day* as a result of a work-related injury;
- you acquired knowledge of an occupational disease.

*Do not count the day of the injury or the day the injured employee returned to work when calculating the number of days absent from work.

The DWC Form-007 can be obtained from the TDI website at http://www.tdi.texas.gov//forms/dwc/dwc007injnc.pdf.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive 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**.

DWC205

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

For TDI-DWC Use Only

Locations of Employer's Business(es)

Addendum to DWC Form-005 or DWC Form-020

Type or print each item on this form in black ink

Check the appropriate box:

☐ **Addendum to DWC Form-005** ***Employer Notice of No Coverage or Termination of Coverage***
☐ **Addendum to DWC Form-020** ***Insurance Carrier Notice of Coverage or Cancellation/Non-renewal of Coverage***

I. PRIMARY EMPLOYER INFORMATION

Primary Employer's Business Name	Federal Employer ID Number

II. ADDITIONAL BUSINESS LOCATIONS

Use this section to add or delete coverage for locations, subsidiaries, and/or separate entities of the primary employer.

Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	
Check One: ☐ADD ☐DELETE	**Effective Date**
Name	**Federal Employer ID Number**
Address (Street or PO Box, City State Zip)	

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

Employer's Report of Non-covered Employee's Occupational Injury or Disease

Type or print in black ink

☐ **Non-subscribing Employer**
☐ **Subscribing Employer - Employee Waived Workers' Compensation Insurance Coverage**

I. EMPLOYER INFORMATION

1. Employer Business Name		
2. Reporting Period (mm/yyyy)	**3. Number of Injured Employees Included on This Report**	
4. Employer Business Mailing Address (Street or PO Box, City, County, State, Zip Code)	**5. Provide the following:**	
	NAICS Codes	**NAICS Employment**
6. Employer Physical Address (Street, City, State, Zip Code)		
7. Employer Phone Number		
8. Federal Employer ID Number		
9. Name of Person Completing Form		
10. Phone Number of Person Completing Form		
11. Title of Person Completing Form		
12. Signature of Person Completing Form	**13. Date of Signature** (mm/dd/yyyy)	

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**
22. Race/Ethnic Identification ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (specify)		

For TDI-DWC Use Only

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)	
24. Type of Location Where Injury/Occupational Disease Occurred ☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations	
25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)
27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)	
28. Reported Cause of Injury	
29. Nature of Injury/Occupational Disease	
30. Equipment Involved in the Injury (if any)	
31. Body Part(s) Affected	
32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)
36. Description of Incident	

NOTE[1]: Title 28 Texas Administrative Code, Chapter 160 requires employers to report work-related deaths, on-the-job injuries and occupational diseases in the form and manner required by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004)

Employer's Name: Employer's FEIN:	For TDI-DWC Use Only

Injury Data for Additional Injured Employee(s)
(reproduce this page, if necessary)

Employer Business Name	
Employer FEIN	**Reporting Period** (mm/yyyy)

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**

22. Race/Ethnic Identification
☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
☐ Other (specify)

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)

24. Type of Location Where Injury/Occupational Disease Occurred
☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations

25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)

27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)

28. Reported Cause of Injury

29. Nature of Injury/Occupational Disease

30. Equipment Involved in the Injury (if any)

31. Body Part(s) Affected

32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)

36. Description of Incident

For TDI-DWC Use Only

Frequently Asked Questions
Employer's Report of Non-covered Employee's Occupational Injury or Disease (DWC Form-007)

Which employers are required to report on-the-job injuries, occupational diseases, and work-related deaths on the DWC Form-007?

The following employers are required to file the DWC Form-007:

- An employer that **does not have** workers' compensation insurance coverage (non-subscriber) and **employs five or more employees who are not exempt** from workers' compensation insurance coverage must file the DWC Form-007 to report all on-the-job injuries and occupational diseases. Examples of exempt employees include certain domestic workers, and certain farm and ranch workers.
- An employer that **has** workers' compensation insurance coverage must file the DWC Form-007 to report an on-the-job injury or occupational disease for an **employee who has waived** workers' compensation insurance coverage in accordance with Texas Labor Code §406.034.

Failure to file the form may subject the employer to administrative penalties.

What do I do if I need to report more than two injured employees?
Copy page three of the form as many times as necessary for reporting additional injured employees.

When do I file the DWC Form-007?
The form must be filed not later than the 7th day of the month following the month in which:

- a work-related death occurred,
- an employee was absent from work for more than one day* as a result of an on-the-job injury; or
- the employer acquired knowledge of an occupational disease.

*Do not count the day of the injury or the day the injured employee returned to work when calculating the number of days absent from work.

NOTE: If no such deaths, injuries, or diseases occurred during a calendar month, no report is required for that month.

Are any fields on the DWC Form-007 optional?
No, all applicable fields must be completed each time the DWC Form-007 is filed.

How do I file the DWC Form-007?
Submit the DWC Form-007 to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by:

- faxing the form to (512) 804-4146; or
- mailing the form to the address listed at the top of the form.

Instructions for Completing Specific Items

Box 5: Employer NAICS Codes*/Employment
List all six-digit NAICS Codes which the employer uses with the FEIN specified in Box 8. Provide the highest employment figure for each NAICS Code for the month of the report. Employment means all employees on your payroll whether full-time, part-time, temporary, or permanent. Attach additional pages, if necessary.

Box 21: Employee NAICS Code*
List the six-digit NAICS Code of the activity that the employee was engaged in at the time of the injury or disease. The code listed must be one of the six-digit NAICS Code numbers reported in Box 5.

Box 22: Race/Ethnic Identification
Check appropriate box and provide requested information, if applicable. Information as to the race/ethnicity of the employee will be maintained for non-discriminatory statistical use.

NOTE: Hispanic, while not a race identification, is included as a separate race/ethnic category. Do not include Hispanic under "white" or "black".

Box 28: Reported Cause of Injury
Enter the most probable cause of the injury or disease. Examples: overexertion due to lifting or pushing, caught between, slip, trip, fall.

Box 29: Nature of Injury/Occupational Disease
Enter the type of injury or occupational disease. Examples: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. For multiple injuries, use most serious.

Box 33: Number of Days Absent from Work

- *Occupational disease*: Must be reported regardless of the number of days the employee is absent from work. Check the appropriate box, including *1 Day or Less*.
- *On-the-job injury*: Must be reported only if the employee is absent from work for more than one day. Do not check *1 Day or Less*.

Box 36: Description of Incident
Provide a short narrative of how the incident occurred. Example: While painting house, fell off ladder and fractured arm.

*Information on NAICS Codes can be found on the United States Census Bureau website at www.census.gov/eos/www/naics. NAICS Codes can also be obtained from the *North American Industry Classification System* published by the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161; e-mail: info@ntis.fedworld.gov.

NOTICE TO EMPLOYEES

_____
(Name of Employer / Nombre del Patron)

COVERAGE: The above employer **DOES NOT** have workers' compensation insurance coverage to protect you from damages resulting from a work-related injury or illness. However, you may have rights under the common law of Texas. Your employer is required to provide you with coverage information when you are hired or whenever the employer becomes, or ceases to be covered by workers' compensation insurance.

SAFETY HOTLINE: The Commission has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division of Workers' Health and Safety at 1-800-452-9595.

COBERTURA: Patron **NO** tiene aseguranza de compensacion para el trabajador para protegerio contra danos que pudieran resultar de una lesion o enfermedad relacionada con su trabajo. Sin embargo, puede ser que usted tenga derechos que la ley comun de Tejas le otorga. Su patron esta obligado a proporcionarle informacion sobre la aseguranza cuando lo contrate para trabajar y asi mismo debe de informarle cuando obtenga o deje de tener seguro de compensacion para el trabajador.

LINEA PARA REPORTAR CONDICIONES INSEGURAS: La Comision ha establecido una linea telefonica gratuita las 24 horas del dia, para reportar condiciones inseguras en el lugar de trabajo que pudiera violar las leyes occupacionales de salud y seguridad. La ley prohibe que los patrones suspendan, despidan o descriminen al empleado o empleada porque el o ella, de buena fe, reporta una alegada violacion occupacional de salud o seguridad. Comuniquese con la Seccion de Salud y Seguridad Laboral al numero 1-800-452-9595.

I have read and understand the above notice.

He leido y entiendo esta notificacion.

EMPLOYEE:
EMPLEADO: _____

EMPLOYER:
PATRON: _____

DATE:
FECHA: _____

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4001 fax • www.tdi.texas.gov

YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code Section 406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:

(1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;

(2) shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;

(3) shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;

(4) shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3), (e)(4) for appropriate language); and

(5) if the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ does not have workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered (non-subscribing) employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits for a work-related injury or occupational disease. In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Division at 1-800-452-9595.

Non-Covered Employer

Texas Workers' Compensation Rule 110.101(e)(4) requires employers who are not covered by workers' compensation, either by election, cancelation or termination of coverage to advise their employees that they do not have workers' compensation insurance coverage.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(4).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

AVISO A LOS EMPLEADOS SOBRE LA COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Name of employer] _____ _____ no cuenta con una cobertura de seguro de compensación para trabajadores. Como empleado de un empleador que no cuenta con una cobertura, usted no es elegible para recibir beneficios de compensación para trabajadores bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador no cubierto (no suscriptor) puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información sobre la disponibilidad de otros beneficios por una lesión o enfermedad ocupacional relacionada con el trabajo. Además, usted podría tener derechos bajo la ley de "Derecho Común de Texas" (Common Law of Texas, por su nombre en inglés), en caso de que usted llegara a sufrir una lesión o enfermedad ocupacional relacionada con el trabajo. Su empleador tiene la obligación de proporcionarle a usted información por escrito sobre la cobertura cuando usted es contratado o cuando su empleador adquiere o deja de tener una cobertura de seguro de compensación para trabajadores.

LÍNEA DIRECTA PARA REPORTAR VIOLACIONES DE SEGURIDAD: La División cuenta con una línea gratuita telefónica que está en servicio las 24 horas del día para reportar condiciones inseguras en el área de trabajo que podrían violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen en contra de cualquier empleado porque él o ella de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la División al teléfono 1-800-452-9595.

EMPLEADORES SIN COBERTURA

El Reglamento 110.101 (e)(4) de Compensación para Trabajadores de Texas requiere que los empleadores que no cuentan con una cobertura de compensación para trabajadores, ya sea por elección, cancelación o anulación de la cobertura notifiquen a sus empleados que no cuentan con una cobertura de seguro de compensación para trabajadores.

Avisos en inglés, español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista y:

1. Mostrarse en un lugar prominente de la oficina de personal del empleador, si es que la hay;
2. Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
3. El título debe ser impreso en tamaño 26, en letra negrita de punto, el tema debe ser impreso en tamaño 18, en letra negrita de punto, y el texto, por lo menos en tamaño 16 en letra negrita de punto normal; y
4. Contener las palabras exactas según lo señalado en el Reglamento 110.101 (e)(4).

El aviso que se muestra al reverso de esta página cumple con los requisitos que se han señalado en la parte de arriba. El negarse a mostrar o proporcionar esta información, según lo requerido en el reglamento es una falta a la ley y a los reglamentos de la División. El infractor podría estar sujeto a sanciones administrativas.

NO MOSTRAR ESTE LADO