

TWCC-1 INSTRUCTIONS

The following instructions correspond to the numbered blocks on the TWCC-1.

Review the reverse side of the TWCC-1 Form for additional information and instructions. You may also call our Customer Service Department at

1. Injured worker's full name (last name first).
2. Injured worker's gender (check either male or female box).
3. Social Security number.
4. Injured worker's home telephone number with area code.
5. Injured worker's date of birth.
6. If employee speaks English, place check in Yes box; if employee cannot speak English, place check in No box and specify primary language (Spanish, etc.).
7. Injured worker's race.
8. Injured worker's ethnic origin; check appropriate box.
9. Injured worker's mailing address (including zip code and county).
10. Injured worker's marital status.
11. The total number of dependent children (under the age of 19).
12. The injured worker's spouse's name, if married.
13. The name and telephone number, if known, of the treating physician first seen by the injured worker who rendered care for the on-the-job injury.
14. The treating physician's mailing address.
15. The date of injury; the actual date injury occurred or first date conditions of disease or illness were noticed by the employee.
16. The time of injury. Check appropriate box for a.m. or p.m.
17. The first full day the injured worker began to lose time due to his/her injury (usually the next working day after injury occurred).
18. The type of injury (sprain, strain, laceration, abrasion, contusion, bruise, amputation, etc.).
19. The part of the body injured or exposed (left index finger, right eye, lower back, etc.).
20. A description of the details and causes of the injury. Be thorough; attach a separate page if needed.
21. Was employee doing his regular job? Check Yes or No.
22. Location of work site where the injury occurred (dock, warehouse, office, job site, etc.).
23. The address where the injury occurred. Include the county and zip code.
24. What caused the injury (lifting, grinder, fall, etc.)?
25. The name and address of any witness to the injury.
26. The date the injured worker is expected to return to work, including light-duty work. If unknown, leave blank or fill in with the word UNKNOWN.
27. Did the injured worker die?
28. The name of the injured worker's immediate supervisor.
29. The date the injury was reported to the injured worker's supervisor.
30. The date of hire of the injured worker.
31. Was the injured worker hired in the state of Texas?
32. The length of employment in the injured worker's current position.
33. The length of time the injured worker has been employed by this company.
34. The injured worker's payroll classification code as reported to the IRS.
35. The occupation or job title of the injured worker.

36. The hourly and weekly rate of pay for the injured worker. If the worker is commissioned, calculate using a 40-hour work week.
37. The amount of time of a full work week for the injured worker.
38. The dollar amount of the injured workers' last paycheck for the number of hours and days based upon an 8-hour workday (the gross paycheck amount, before taxes).
39. Is the injured worker the owner, partner (including controlling, limited, or silent) or corporate officer of the business? Check Yes or No box.
40. The name and title of the individual completing the TWCC-1 form.
41. The name of the business. Include any DBA or subsidiary names if different from the parent name of the business.
42. The mailing address and telephone number of the injured worker's business office.
43. The street address of the business office if different from the mailing address.
44. The Federal Tax Identification number (IRS#) of business. If no IRS# is established, please enter the Social Security number of the business owner.
45. The primary Standard Industrial Classification (SID) code. (See TWCC-1 special instructions on back.)
46. The specific SIC code. (See TWCC-1 special instructions on back.)
47. The Texas Comptroller taxpayer number of the business.
48. The name of your workers' compensation insurance company providing the business current coverage.
49. Your policy number and policy effective date.
50. Did the business request and receive accident prevention services within the past 12-month period?
51. The signature, title and date of the individual completing the TWCC-1 form or person responsible for reporting worker's compensation reports (***signature is required***).

POLICY NUMBER

When must an employer file the TWCC-1?

An employer must file the TWCC-1 for each injury that results in more than one day's absence from work for the injured employee, occupational disease reported by an employee, and death (Rule 120.2)

Who receives a copy of the TWCC-1?

- (1) The designated adjusting firm electronically submits the information to the TWCC. Do Not Mail anything to the Texas Workers' Compensation Commission.
- (2) Insurance carrier or its designated adjusting firm.
- (3) Employee.

How do employers get the new form?

The new TWCC-1 forms are available from the insurance company or the Texas Workers' Compensation Commission also sells packets of forms.

When should the employer file TWCC-6 (Supplemental Report)?

If the employer's First Report of Injury did not show the injured employee had returned to work, an Employer's Supplemental Report of Injury should be completed and filed within 3 days after the employee returns to work, or has additional days of disability, and within 10 days if the employee has an increase or decrease of earnings during their disability, and/or if the employee is terminated or resigns. In the event of the death of an employee, this report should be filed immediately. This report should also be filed when the employee starts to lose time from work due to the injury. (Refer to the reverse side of the form for specific and additional instructions.)

When should (TWCC-3) Wage Statement be filed?

If an employee is disabled at least 8 days, the employer shall file a signed wage statement with the insurance carrier and the Commission within 30 days of receipt of notice of the injury.

What wages should be submitted?

Submit wages earned by the employee 13 consecutive weeks prior to the date of injury. If the employee was not employed 13 consecutive weeks prior to the injury, a similar employee performing same or similar services.

What right does the employer have to deny a claim?

The employer has the right to contest the compensability of an employee's injury if the insurance carrier accepts liability for the payment of benefits. You should discuss any questionable claim with your company claim department.

How does the employer obtain reimbursement for benefits paid to an injured worker?

The employer should notify the Texas Workers' Compensation Commission and the insurance company within 14 days after the date of initial payment. An employer who fails to file the report of injury or occupational disease, as required by Art. 8308-5.05 of the Texas Workers' Compensation Act, waives the right to reimbursement of any voluntary payments.

Is light-duty work available?

This is a question often asked by the Benefits Services Division. The goal of light duty is to return the employee to work as quickly as possible within medical restrictions. Returning to work motivates the employee, eases financial burden, minimizes the cost of compensation, and allows the employer to maintain an effective workforce.

Light-duty positions come in various forms. The employer may fill another position or create a temporary position based on the restrictions provided. Wages are based on normal rates for the position. Compensation will supplement lower rates of pay during the period of disability. Any offers of employment must be made under specific guidelines set forth by the Texas Workers' Compensation Commission.

File original with employer's carrier.
File copy with injured employee.

CARRIER'S CLAIM #
TWCC #

SUPPLEMENTAL REPORT OF INJURY

DO NOT SEND THIS FORM TO TEXAS WORKERS' COMPENSATION COMMISSION UNLESS REQUESTED.

WHEN AND WHERE TO FILE: For all injuries occurring January 1, 1991 or after that require a TWCC-1, Employer's First Report of Injury, to be filed, the employer must file by first class mail or personal delivery a Supplemental Report of Injury (TWCC-6) with the employer's workers' compensation carrier and the injured employee: 1) within 3 days after the injured employee returns to work; 2) within 3 days when the employee, after returning to work, has an additional day or days of disability because of the injury; 3) within 10 days after the end of each pay period in which the employee has an increase or decrease of earnings during the time the employee is entitled to temporary income benefits; 4) within 10 days after the employee resigns or is terminated. If the injured employee is no longer employed by the employer, the employee is responsible for providing information to the carrier about amounts of earnings or offers of employment. The employee may use a TWCC-6, Employer's Supplemental Report of Injury for this purpose. **An employee has disability if he/she is unable to work as a result of the injury or has returned to work earning less than pre-injury wages because of the injury.**

EMPLOYEE INFORMATION

1. Employee's Name (Last, First M.I.) and Telephone No. ()	2. Social Security No.	3. Date of Injury (m-d-y)
4. Employee's Mailing Address (Street or P.O. Box)		
City	State	Zip Code

TO EMPLOYER: Based on above rule requirements, check boxes which show reasons for filing Supplemental Report of Injury this date:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> employee returned to work
Complete Block 5a or 5b
Complete Blocks 6 and 7 | <input type="checkbox"/> additional day(s) of disability
Complete Block 5b
Complete Block 7 | <input type="checkbox"/> change in weekly earnings after injury
Complete Blocks 5a or 5b
Complete Blocks 7 and 8 | <input type="checkbox"/> employee terminated/resigned
Complete Block 5a or 5b
Complete Block 7
Complete Block 9 |
|---|--|---|---|

5. a) If initial filing of TWCC-6, first day of disability due to injury (m-d-y)	5. b) If second or subsequent filing of TWCC-6, give first day of disability due to injury <u>for this period only</u> (m-d-y)
6. Date of Return to Work _____ (Check box) <input type="checkbox"/> Full Duty, Full Pay <input type="checkbox"/> Limited Duty: Full Pay <input type="checkbox"/> Reduced Pay	7. Weekly and Hourly Earnings at Time of This Report (Check box) <input type="checkbox"/> Same as Preinjury Wages \$ _____ weekly <input type="checkbox"/> Increase from Preinjury Wages <input type="checkbox"/> Decrease from Preinjury Wages \$ _____ hourly
8. No. of Hours Working Weekly at Time of This Report _____ (Check box) <input type="checkbox"/> Increase from Preinjury Hours Worked Weekly <input type="checkbox"/> Same as Preinjury <input type="checkbox"/> Decrease from Preinjury Hours Worked Weekly	9. If the employee resigns or is terminated, fill in the appropriate section. <input type="checkbox"/> Date of Resignation (m-d-y) _____ <input type="checkbox"/> Date of Termination (m-d-y) _____
10. If applicable, eight days of disability began on (m-d-y) [see above definition of disability]	9a. Reason for Resignation or Termination
11. Has injured employee died? If so, give date of death (m-d-y)	12. Was employee on limited duty at time of termination? <input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYER INFORMATION

13. Employer's Business Name	14. Telephone No. ()	
15. Employer's Business Mailing Address (Street or P.O. Box)		
City	State	Zip Code
16. Name or Workers' Compensation Carrier for Above Injury		
17. The information provided in this report is accurate to the best of my knowledge. It may be relied upon for evaluation of the named employee's eligibility for benefits.		
Signature and Title of Person Completing Form	<input type="checkbox"/> Employer <input type="checkbox"/> Employee	Date

TWCC-6
(Supplemental Report of Injury)

WHEN AND WHERE TO FILE: *For all injuries occurring January 1, 1991 or after* that require the filing of a TWCC-1, Employer's First Report of Injury, the employer must file a Supplemental Report of Injury (TWCC-6) with the employer's workers' compensation insurance carrier and the injured employee by first class mail or personal delivery.

1. within 3 days after the injured employee returns to work;
2. within 3 days when the employee, after returning to work, has an additional day or days of disability because of the injury;
3. within 10 days after the end of each pay period in which the employee has a change in earnings as a result of the injury during the time the employee is entitled to temporary income benefits. An employee is entitled to temporary income benefits if he/she has disability and has not reached maximum medical improvement. Maximum medical improvement means either:
 - 1) 104 weeks from the date temporary income benefits begin to accrue; or
 - 2) the date a doctor certifies that, based on reasonable medical probability, the injured employee can no longer reasonably anticipate further recovery or lasting improvement from the compensable injury,whichever comes first; and
4. within 10 days after the employee resigns or is terminated

An employee has disability if he/she is unable to work as a result of the injury or has returned to work earning less than pre-injury wages because of the injury.

When an employee is no longer employed by the employer for whom he was working when injured, the employee is responsible for providing information directly to the insurance carrier about the existence or the amount of any earnings or any offers of employment. The Supplemental Report of Injury may be used for this purpose.

This report is considered filed with the insurance carrier and the injured employee when personally delivered or postmarked. Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed \$500.

[Article 8308-5.05 (c), (e); Rules 120.3, 129.4]

DO NOT SEND THIS FORM TO TEXAS WORKERS' COMPENSATION COMMISSION UNLESS REQUESTED.

Send the specified copies to your
Workers' Compensation Insurance Carrier
 and the injured employee.
***Employers-Do not send this form to the
 Texas Workers' Compensation Commission,
 unless the Commission specifically requests a direct
 filing.**

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

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

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 Standard Industrial Classification (SIC) Code* (4 digit)	46. Specific SIC Code* (4 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 <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>			
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____			

INSTRUCTIONS FOR EMPLOYER FIRST REPORT OF INJURY OR ILLNESS (TWCC-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (Form TWCC - 1 (2-91)) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers-Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed \$500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 - 5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers-Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.** The Commission's Health and Safety Division will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Commission or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

- Items 2, 7, 8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Commission to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
- Item 4: If no home phone, please provide a phone number where the employee can be reached.
- Items 5, 15, 17, 26, 29, 30: Enter data in month, day, year format. Example: 08-13-54.
- Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
- Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
- Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g. cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
- Item 22: State the exact work-site location of the injury, e.g. construction site, office area, storage area, etc.
- Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
- Items 32, 33: Enter date in month-year format. Example: 02-56.
- Item 37: Enter the number of days or hours that make up a full work week for your employees.
- Item 45: Enter the 4-digit primary standard industrial classification code (SIC) of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Employment Commission.
- Item 46: For companies with a single SIC code, the specific code is the same as the primary code. For companies with multiple SIC codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.