Important Information Regarding Workers' Compensation Claims under your Texas Mutual Insurance Company Policy

By law, all employers and injured workers have specific rights and responsibilities. We recommend that you review these and obtain any necessary forms at www.tdi.state.tx.us/wc/indexwc.html or call 800-252-7031. To avoid delays, all Workers' Compensation claims and bills should be submitted directly to Texas Mutual Insurance Company. Below are some general guidelines for your information:

Employer Responsibilities:

The employer is required to file an Employers' First Report of Injury or Illness (DWC Form-1) with Texas Mutual Insurance Company within 8 days after the worker's injury or notification of the workers' injury. You must also provide a copy to the injured worker or worker's representative along with "Notice of Injured Employee Rights and Responsibilities".

The fastest way to report an injury is online at www.texasmutual.com. If you cannot report online, you may report by phone at (800) 892-5246 or send a completed DWC-Form 1 by fax to (877) 404-7999 or by mail to Texas Mutual Insurance Company, P.O. Box 12029, Austin, TX 78711-2029.

Injured Worker Responsibilities:

The injured worker must report the injury to the employer within 30 days of the date of injury.

The injured worker must choose a treating doctor and must know if they are participating in a Workers' Compensation Health Care Network. If so, they should choose a doctor from the network's treating doctor list. If not, they should choose a doctor from the Approved Doctor List kept by the Division of Workers' Compensation.

The injured worker must inform the doctor how he was injured and that it is work-related and covered by Workers' Compensation coverage to avoid being held financially responsible.

The injured worker is required to file an Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041) with the Texas Department of Insurance Division of Workers' Compensation within one year of the injury.

Please Note:

Health care providers are required by state law to submit medical bills to the company within 95 days from the date of service. A health care provider may not bill you for treatment of a work-related injury or illness that is covered by Workers' Compensation. If you receive any medical bills from a health care provider, you should immediately contact them and provide them with the information regarding your Workers' Compensation policy. The injured worker and the employer should NOT pay any medical bills. If you do, you must request reimbursement from the company within 14 days and you may not be reimbursed for the entire amount.

Please contact us at (800) 252-9435 if you have any problems or need any assistance on your claim.

VFIS of Texas
3420 Executive Center Drive, Suite 301, Austin, TX 78731-1626

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 _____