

### **Texas Department of Insurance – Division of Workers' Compensation Forms**

The 2007 Texas Legislature passed a law mandating the Texas Department of Insurance Division of Workers' Compensation ("DWC") to aggressively begin assessing administrative penalties against employers that have opted out of the Texas Workers' Compensation system ("Nonsubscribers") but do not file the EMPLOYER'S NOTICE OF NO COVERAGE OR TERMINATION OF COVERAGE (DWC005) timely. A Nonsubscriber must file the DWC005 annually on the anniversary date of the original filing for as long as it remains a Nonsubscriber. Nonsubscribers with multiple locations must also file the LOCATIONS OF EMPLOYERS' BUSINESS(ES) (DWC205).

Nonsubscribers must also post the NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS (DWC Notice 5) about the workplace in such a way that each employee is likely to see the notice on a regular basis. This notice must contain the exact words as prescribed by the Workers' Compensation Rules and be printed in English, Spanish and any other language common to its employees in specified print types. This notice must also be provided to each new employee at time of hiring.

Nonsubscribers are further required to file a NON-COVERED EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS (DWC007) listing all on-the-job injuries resulting in more than one day's absence from work for the injured employee, occupational diseases of which the employer had knowledge (even if there is no lost time) and any fatalities. The completed DWC007 listing all such reportable injuries or illnesses occurring during a calendar month must be filed with the DWC no later than the 7th day of the following month.

Example copies of these DWC forms and notices are printed on the back of this document. Failure to file these DWC forms timely, or post or provide required notices exposes the Nonsubscriber to administrative penalties. The enclosed DWC Notice 5 has been prepared by Texas Healthcare Foundation for your signing and filing. As required, DWC007 will also be prepared Texas Healthcare Foundation and mailed to your for signing and filing.

**Any questions,  
just call 800-716-6777  
THF will be glad to help.**

**NON-COVERED EMPLOYER'S REPORT OF  
OCCUPATIONAL INJURY OR ILLNESS**

REPORT FOR MONTH OF: \_\_\_\_\_ YEAR: \_\_\_\_\_

**EMPLOYER DATA**

1. Employer's Business Name		2. Federal Employer ID No.		3. Telephone No.		8. NAICS CODES (Employment)	
4. Employer's Business Mailing Address (Street or P.O. Box)						NAICS Codes	NAICS Employment
5. City		County		State		Zip	
6. Employer's Representative (Print/Type Name and Title of Person Completing Form)				7. Employer's Representative's Signature			
Last		First		MI		I certify the information provided is correct	
						Date (m-d-y)	

**INJURY DATA**

1. Employee's Name			10. Date of Injury/Illness (m-d-y)		11. Employee 6 Digit NAICS code		12. Equipment		13. Nature of IN/ILL		14. Body Part(s) Affected		
Last			First		MI								
16. Social Security Number			18. Sex		17. DOB (m-d-y)		22. Description of Incident					23. Lost Time	
			<input type="checkbox"/> M <input type="checkbox"/> F									<input type="checkbox"/> > 1 Day - 7 Days <input type="checkbox"/> 8 Days or More	
18. Race/Ethnic Identification			19. Cause of Injury		20. Location of Injury (see Instructions)		25. DWC USE ONLY					24. Occupational Disease	
<input type="checkbox"/> White (not of Hispanic origin) <input type="checkbox"/> Black (not of Hispanic origin)			<input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C							<input type="checkbox"/> YES <input type="checkbox"/> NO	
21. Employee's Occupation			21a. Hourly Wage									26. Fatality	
												<input type="checkbox"/> YES <input type="checkbox"/> NO	
												Date (m-d-y)	



Send DWC FORM-5 by certified mail or personal delivery to:  
TEXAS DEPARTMENT OF INSURANCE  
DIVISION OF WORKERS' COMPENSATION  
7551 Metro Center Drive, Suite 100  
Austin, Texas 78744

**EMPLOYER NOTICE OF  
NO COVERAGE OR  
TERMINATION OF COVERAGE**

**INSTRUCTIONS**

**WHO MUST FILE:** All employers (including former sole proprietors who have formed corporations which have only one employee) must file a DWC FORM-5 with the Texas Department of Insurance, Division of Workers' Compensation unless the employer:

- a. has workers' compensation insurance;
- b. is a certified self-insurer;
- c. is a self-insured political subdivision; or
- d. only employs employees who are exempt from coverage under the Texas Workers' Compensation Act.

**WHEN TO FILE:** See reverse side of form.

**NO COVERAGE OR TERMINATION OF COVERAGE**

1. Check one of the following:

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

The below named employer has **TERMINATED** workers' compensation insurance coverage, effective date \_\_\_\_\_ of Policy Number \_\_\_\_\_ and has notified the \_\_\_\_\_ Insurance Company on (date) \_\_\_\_\_ pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.007. Notice has been (will be) provided to employees on the following date: \_\_\_\_\_.

**EMPLOYER INFORMATION (PLEASE TYPE OR PRINT):**

2. Employer Business Name \_\_\_\_\_ 3. Federal Tax ID Number \_\_\_\_\_

4. Employer Business Mailing Address \_\_\_\_\_

5. Description of Business Operations. Identify type and nature of business. \_\_\_\_\_

6. Name, Federal Tax ID Number and Address of each Business Location covered by this report, if different from the above. To identify additional locations, submit a DWC FORM 205.

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Federal Tax ID Number \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Federal Tax ID Number \_\_\_\_\_

PERSON PROVIDING THIS INFORMATION		DIVISION DATE STAMP HERE:	
7. Name _____			
8. Title _____			
9. Signature _____		10. Date _____	



**NOTICE TO EMPLOYEES CONCERNING  
WORKERS' COMPENSATION IN TEXAS**

**COVERAGE:** (\_\_\_\_\_) has elected not to obtain 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 employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. 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 HOTLINE:** The Division 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 Workers' Health & Safety at 1-800-452-9595.

**AVISO A EMPLEADOS SOBRE COMPENSACIÓN  
PARA TRABAJADORES EN TEXAS**

**COBERTURA:** (\_\_\_\_\_) ha elegido no obtener cobertura de compensación para trabajadores. Como empleado de un empleador que ha elegido no obtener seguro de compensación para trabajadores usted no es elegible para recibir beneficios de compensación bajo la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador sin cobertura puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información acerca de la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de "Derecho Común" de Texas, si usted ha sufrido una lesión o enfermedad relacionada con su trabajo. Es requerido que su empleador le proporcione información acerca de la cobertura, por escrito, cuando es contratado o cuando su empleador obtiene o deja de tener cobertura de seguros de compensación para trabajadores.

**LÍNEA DIRECTA PARA REPORTAR CONDICIONES INSEGURAS:** La División ha establecido una línea telefónica gratuita las 24 horas, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen contra un empleado o empleada porque él o ella, de buena fe, reporta una presunta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.