

Non Subscriber – 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-5 (formerly TWCC Form 5) that you must complete annually.
Complete and send in to the state by Certified Mail, return receipt requested.
2. The DWC Form-7 (formerly TWCC 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.

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: <input type="checkbox"/> 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. <input type="checkbox"/> 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: _____.
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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	
7. Name	
8. Title	
9. Signature	10. Date

DIVISION DATE STAMP HERE:



INSTRUCTIONS FOR EMPLOYER NOTICE OF NO COVERAGE OR TERMINATION OF COVERAGE

The following employers are required to file a DWC FORM-5 with the Texas Department of Insurance, Division of Workers' Compensation:

1. Employers who elect not to be covered by workers' compensation insurance must file a DWC FORM-5 by the **earlier** of:
 - a. 30 days after hiring an employee who is subject to coverage under the Texas Workers' Compensation Act; or
 - b. 30 days after receipt of a Division request for filing of a DWC FORM-5;
2. Employers principally located outside Texas must file a DWC FORM-5 within 10 days after receipt of a Division request for information regarding coverage status; or
3. Employers who cancel their workers' compensation insurance must file a DWC FORM-5 within 10 days after notifying their insurance carrier of cancellation **unless** the employer:
 - a. purchases a new policy; or
 - b. becomes a certified self-insurer.

If an employer chooses to cancel their insurance, coverage must be extended until the "effective date" of withdrawal (i.e., the **later** of 30 days after filing the DWC FORM-5 with the Division OR the policy cancellation date), during which time the employer is obligated to pay accrued premiums. The employer is not required to extend coverage beyond the end of the policy period.

ANNUAL FILING: Employers must file a new DWC FORM-5 **annually** on the anniversary date of the original filing.

APPLICATIONS/EXEMPTIONS: An employer who is: (1) covered by workers' compensation insurance; (2) a certified self-insurer; (3) a self-insured political subdivision; or (4) whose only employees are exempt from coverage under the Texas Workers' Compensation Act (e.g. domestic workers, certain farm and ranch workers) is not required to file a DWC FORM-5.

POSTING AND NOTICE REQUIREMENTS

An employer must **post** the following notice in the workplace in English, Spanish and other language common to the workplace in the print type specified by Workers' Compensation Rules whenever the employer: (1) elects not to be covered by workers' compensation insurance; (2) cancels or terminates workers' compensation insurance; (3) withdraws from self-insurance; or (4) whose workers' compensation coverage is cancelled by the insurance company. This notice must **also be provided** to each employee:

- a. at the time of hiring;
- b. when an employer elects not to be covered by workers' compensation insurance;
- c. within 15 days of when an employer notifies the insurance carrier that the employer is dropping coverage without maintaining continuous coverage under a new policy; or
- d. within 15 days of when an employer's workers' compensation policy is canceled by the insurance company.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (_____) has elected not to obtain workers' compensation insurance coverage.
Name of Employer

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 the Workers' Health & Safety at 1-800-452-9595.

Failure to file a DWC FORM-5 or to post or provide the required notices may subject the employer to administrative penalties.



Primary Employer's Business Name/Insured	Federal Tax ID No.	Current Policy No.	DWC Use Only (Microfilm)
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LOCATIONS OF EMPLOYERS' BUSINESS(ES)

Please Type

DWC FORM-5 **DWC FORM-20**

Please list additional locations, subsidiaries, and/or separate entities of the primary employer for attachment to forms DWC FORM-5, DWC FORM-20 and DWC FORM-20A. If filing this form with a DWC FORM-20A, indicate if the listed location is an addition or deletion to the existing policy.

Name _____	Check One: ADD DELETE
Address _____	Effective Date _____
City _____ State _____ Zip _____	Federal Tax ID Number _____
Name _____	Check One: ADD DELETE
Address _____	Effective Date _____
City _____ State _____ Zip _____	Federal Tax ID Number _____
Name _____	Check One: ADD DELETE
Address _____	Effective Date _____
City _____ State _____ Zip _____	Federal Tax ID Number _____
Name _____	Check One: ADD DELETE
Address _____	Effective Date _____
City _____ State _____ Zip _____	Federal Tax ID Number _____
Name _____	Check One: ADD DELETE
Address _____	Effective Date _____
City _____ State _____ Zip _____	Federal Tax ID Number _____
Name _____	Check One: ADD DELETE
Address _____	Effective Date _____
City _____ State _____ Zip _____	Federal Tax ID Number _____



**INSTRUCTIONS FOR COMPLETING THE NON-COVERED REPORT
OF OCCUPATIONAL INJURY OR ILLNESS (DWC FORM-7)**

All on-the-job injuries resulting in more than one day lost time, all occupational diseases of which the employer has knowledge (regardless of lost time), and all fatalities occurring during the calendar month must be reported. If no such injuries, diseases or fatalities have occurred during the calendar month, no report is required. Lost time begins the day after the day of the injury. For example, an employee injured on 1-1-92 who returns to work on 1-4-92 would have a lost time of 2 days since the day of the injury does not count, nor does the day the employee returned.

Use as many supplemental sheets as needed (form can be reproduced). The first sheet must have all Employer as well as Injury Data completed. Subsequent sheets must have the Employer's Business Name, Federal Employer Identification Number, and Injury Data completed.

The completed form must be personally delivered or mailed **not later than the seventh day** of the following month to the:

Texas Department of Insurance
Division Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

Month - Enter the calendar month. **Year** - Enter the calendar year.

Employer Data

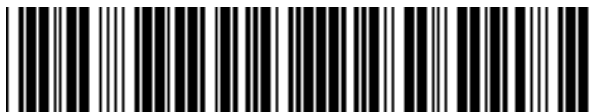
ITEM: INSTRUCTIONS:

1. **Employer's Business Name** - Use employer DBA (Doing Business As). If employer does not have a DBA, use other business name.
2. **Federal Employer ID No.** - (FEIN) Obtain this number from financial or tax account records. If the employer has more than one FEIN, use a separate DWC FORM-7 for each separate FEIN.
3. **Telephone Number** - Business telephone number of the individual completing the report.
4. **Employer's Business Mailing Address** - Give the street address and post office box number (if applicable).
5. **City, County, State, Zip** - Name of County must be included.
6. **Employer's Representative** - Print or type name and title of individual completing the report.
7. **Employer's Representative's Signature** - Signature of Employer's Representative certifying the information provided on the form is correct.
8. **Employer's Six-Digit NAICS Codes With Employment** - List all 6-digit NAICS Codes which the employer uses with the FEIN specified in block 1 only. If unknown, consult Texas Workforce Commission Form C-3, Employer's Quarterly Report, block 5, for this information. Give 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. Use a separate sheet for information that does not fit in the block.**

Injury Data

9. **Employee's Name** - List the full name of the individual who suffered an injury, occupational disease, or fatality.
10. **Date of Injury/Illness** - Enter the date the injury occurred or the date the employer first had knowledge of the occupational disease.
11. **Employee 6-Digit NAICS** - List the 6-digit NAICS Code of the activity that the employee was engaged in at the time of the injury/illness. The code listed must be one of the 6-digit NAICS Code numbers reported by the employer in block 8. If NAICS Codes are unknown, consult Texas Workforce Commission (TWC) Form C-3, Employer's Quarterly Report, block 5, for this information.**
12. **Equipment** - List equipment (if any) involved in the injury.
13. **Nature of INJ/III** - Enter the type of injury/illness. For example: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. Use most serious condition if multiple injuries.
14. **Body Part(s) Affected** - List the most seriously injured part(s). For example: head, hand, torso, leg, back, ankle, wrist, lungs, skin, eyes.
15. **Social Security Number** - Enter the Employee's Social Security Number.
16. **Sex** - Check appropriate block. Information as to the sex of the employee will be maintained for non-discriminatory statistical use.
17. **DOB** - DATE OF BIRTH - Enter month, day and year.
18. **Race/Ethnic Identification** - Check appropriate block. 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."
19. **Cause of Injury** - Give the most probable cause of injury/illness. Example: Overexertion due to lifting or pushing; caught between; slip; trip; fall.
20. **Location of Injury** - Check block A if injury occurred at primary business location. Check block B if injury occurred at on-site job location. Check block C if injury occurred while traveling between work locations.
21. **Occupation** - List the type of work the injured individual was engaged in at the time of the injury/illness. For example: carpenter, pipe fitter.
22. **Description of Incident** - Give a short narrative of how the incident occurred. For example, "While painting house, fell off ladder and fractured arm.
23. **Lost Time** - If the employee lost more than one day after the date of the injury but less than 8 days, check > 1 Day - 7 Days. If the employee lost 8 or more days check the 8 Days or More block.
24. **Occupational Disease** - If employee suffered an Occupational Disease, check "YES", if not, check "NO."
25. **Fatality** - Did the injury/illness result in the death of the employee? If yes, check "YES" and list date of death. If no, check "NO."
26. **DO NOT WRITE IN THIS BLOCK. IT IS RESERVED FOR TWCC USE ONLY.**

** For companies that do not report to TWC, NAICS code can be found in 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.



DWC FORM - 7
(Non-covered Employer's Report of Occupational Injury or Illness)

Certain non-covered employers, described below, are required to file reports with DWC using DWC FORM-7, Non-covered Employer's Report of Occupational Injury or Illness. Employers must list on the DWC FORM-7 all fatalities, all occupational diseases of which the employer had knowledge (even if there is no lost time) and all on-the-job injuries resulting in more than one day's absence from work for the injured employee. The completed DWC FORM-7 reporting all such injuries that have occurred during a calendar month must be filed no later than the 7th day of the following month.

Non-covered employers are required to file this form if they have more than 4 employees*

* All employees are counted for these requirements unless they are domestic workers, or casual workers engaged in employment incidental to a personal residence, or are certain farm and ranch workers, or are workers covered by a method of compensation established under federal law.

The DWC FORM -7 is considered filed when personally delivered or postmarked. Send the DWC FORM-7 and the DWC FORM-7 Supplemental to the Texas Department of Insurance, Division of Workers' Compensation, Customer Services, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

(Rule 160.2 Non-Subscribing Employer's Report of Injury)



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

REPORT FOR MONTH OF: _____ YEAR: _____

EMPLOYER DATA

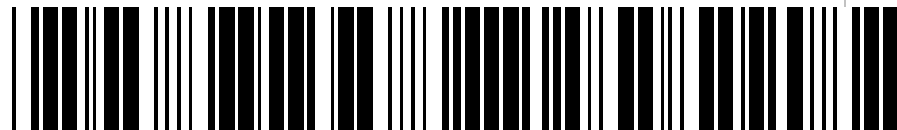
1. Employer's Business Name	2. Federal Employer ID No.	3. Telephone No.
4. Employer's Business Mailing Address (Street or P.O. Box)		
5. City	County	State
		Zip
6. Employer's Representative (Print/Type Name and Title of Person Completing Form)		7. Employer's Representative's Signature
Last	First	MI
I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

8 NAICS CODES /Employment	
NAICS Codes	NAICS Employment

INJURY DATA

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

Commission date stamp



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 ocupacionales de salud y seguridad. La ley prohíbe que los patrones suspendan, despidan o descriminen al empleado o empleada porque el o ella, de buena fe, reporta una alegada violacion ocupacional 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 leído y entiendo esta notificación.

EMPLOYEE:

EMPLEADO: _____

EMPLOYER:

PATRON: _____

DATE:

FECHA: _____

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (_____) has elected not to

Name of Employer

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.

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AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [_____] ha elegido no

Nombre del Empleador

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.