Workers' Compensation 101

Jennifer Ruedas
WC Claims Manager

Adriana Talbot
WC Program Consultant

TASB™ RISK FUND | 50 YEARS STRONG

Course Objectives

- Introduction to Workers' Compensation
- Identifying the Benefits of a Workers' Compensation Program
- Understanding the Claim Reporting Process
- Understanding Workers' Compensation Forms and Deadlines
- Strategies for Effectively Managing Claims

Workers' Compensation in Texas

State-regulated program

First laws enacted in 1913, in Texas

Formulated after the Industrial revolution

Texas Department of Insurance (TDI)

- Founded in 1876 as the Department of Insurance, Statistics, and History
- Regulates state insurance industry
- Oversees Texas workers' compensation system

TDI Texas Department of Insurance

Image source: https://www.tdi.texas.gov/wc/index.html

Division of Workers' Compensation (DWC)

- Administers and operates the Texas workers' compensation system
- Mediates the dispute process
- Serves as resource

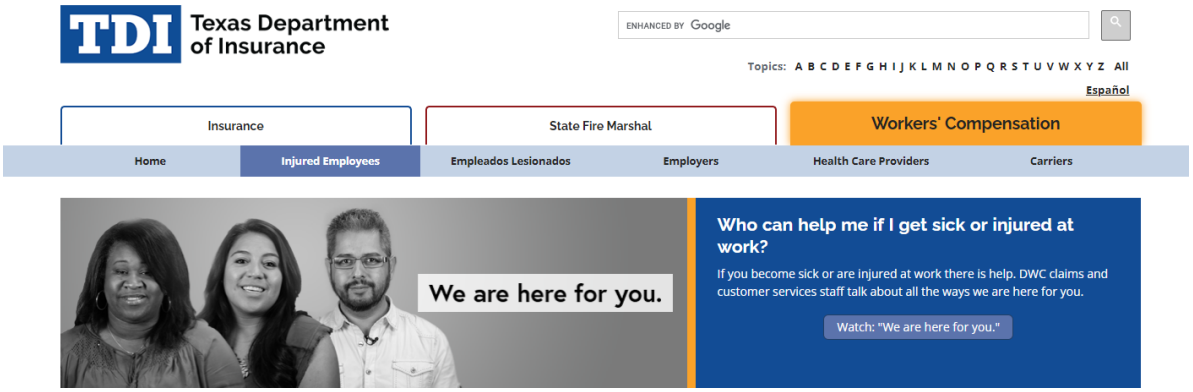


Image source: https://www.tdi.texas.gov/wc/index.html

Texas Department of Insurance (TDI) & Division of Workers' Compensation (DWC)

Both have authority to assess penalties and fines related to workers' compensation in Texas

Employer Responsibilities

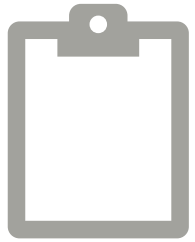
Political Subdivisions in Texas are required to create a record of every known or reported on-the-job injury or illness

A record is a First Report of Injury/Illness (FROI)

TASB™ RISK FUND | 50 YEARS STRONG

Employer Responsibilities

Create the Record

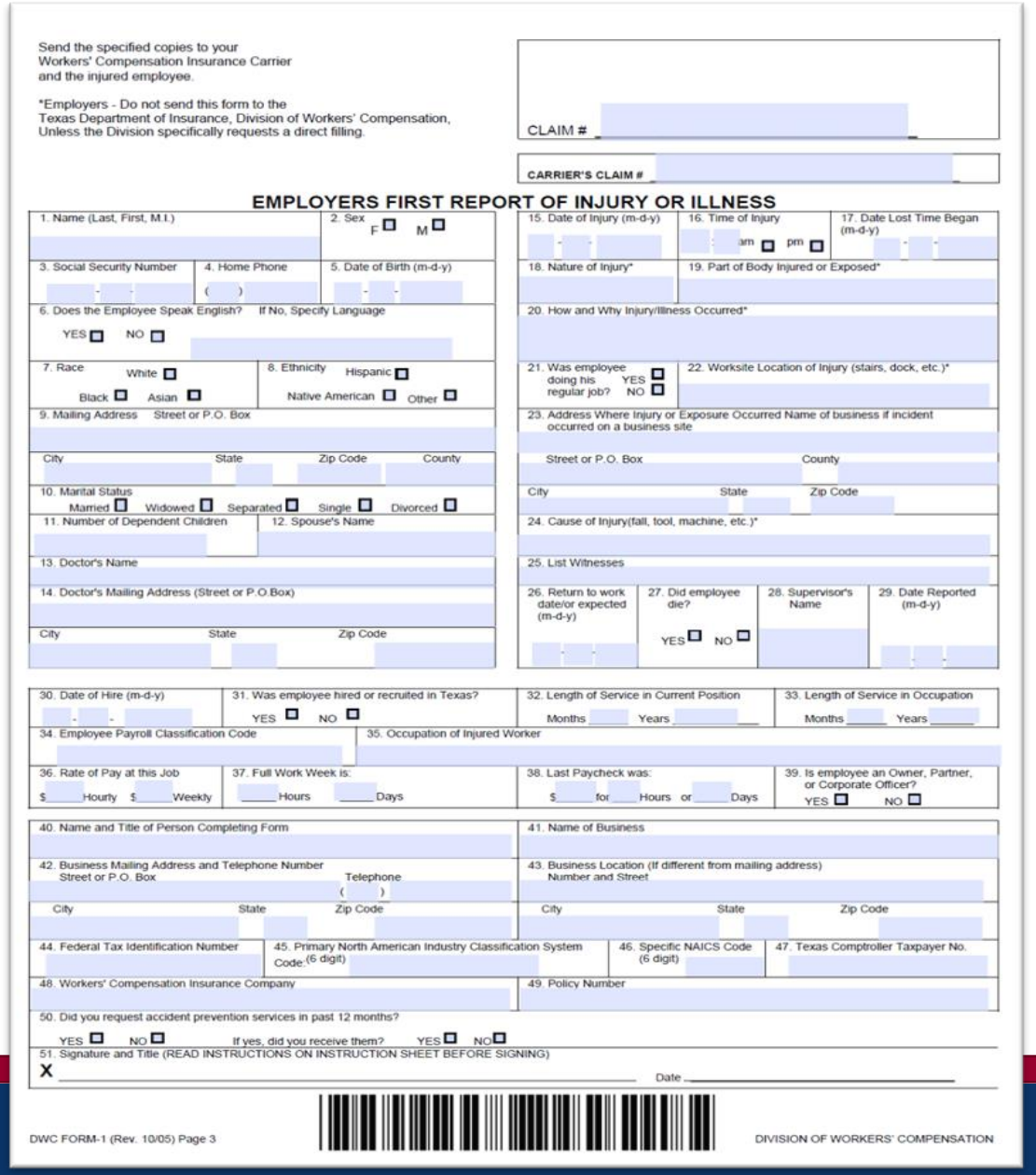


Copy employee with rights & responsibilities

File when required by State

First Report of Injury/Illness (FROI)

- The record
- DWC 1
- FROI



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 | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language YES NO | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

City State Zip Code County | Street or P.O. Box County

10. Marital Status Married Widowed Separated Single Divorced | City State Zip Code

11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)*

13. Doctor's Name | 25. List Witnesses

14. Doctor's Mailing Address (Street or P.O.Box) | 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)

City State Zip Code

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

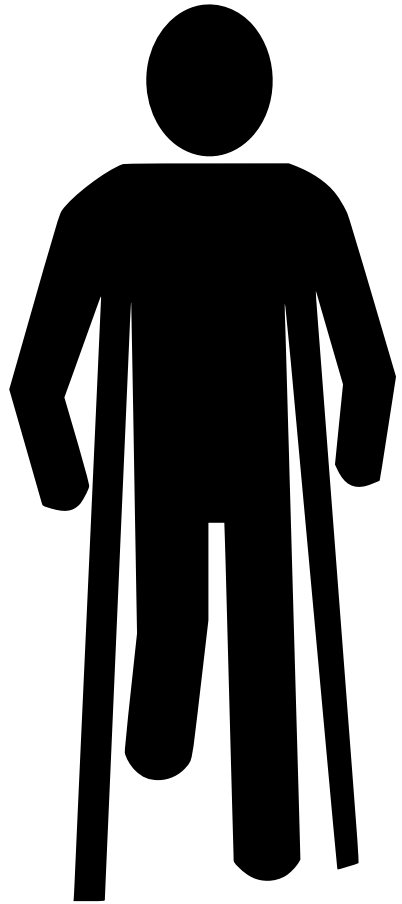
DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

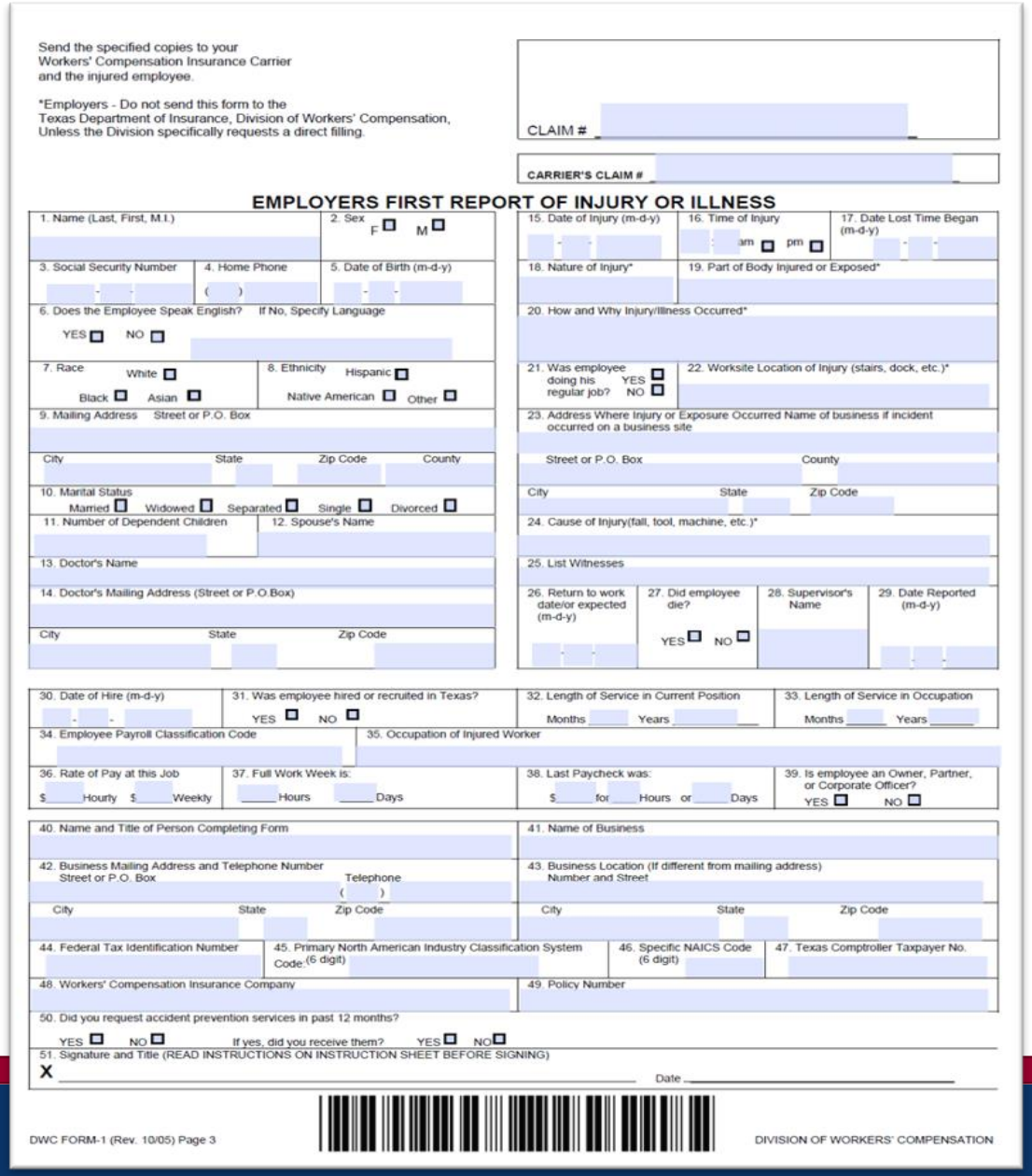
Injury/Claim

- Physical
- Occupational Disease/Illness
- Psychological Trauma



Occupational Disease/Illness

- A disease that arises out of and in the course of employment, causing damage or harm to the physical structure of the body



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 | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language YES NO | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

City State Zip Code County | Street or P.O. Box County

10. Marital Status Married Widowed Separated Single Divorced | City State Zip Code

11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)*

13. Doctor's Name | 25. List Witnesses

14. Doctor's Mailing Address (Street or P.O.Box) | 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)

City State Zip Code

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

DWC FORM-1 (Rev. 10/05) Page 3 DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

COVID-19

- Ordinary disease of life, general public is exposed

TASB™ RISK FUND | 50 YEARS STRONG

COVID-19

When to Report

- Employee insists that if not for work, they wouldn't have contracted the virus

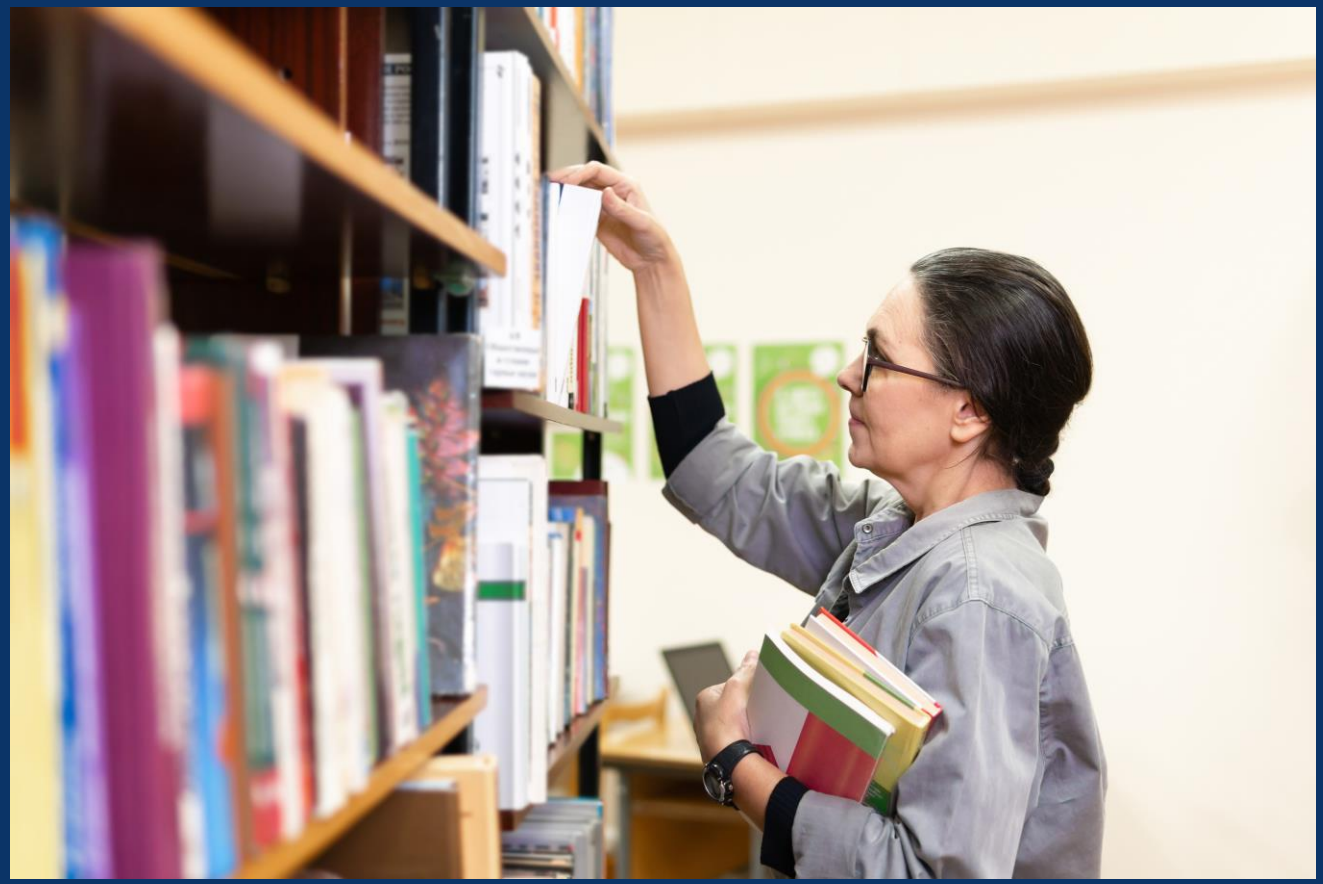
- As of June 15, 2023, presumption no longer in effect for first responders with dates of injury/illness on or after March 13, 2020

General Definitions

- Compensable injury
- Course and scope of employment

Labor Code **§401.011, General Definitions**

Scenario #1



TASB™ RISK FUND | 50 YEARS STRONG

Employee Strains Back Moving a Box of Books

- Informs co-worker
- Co-worker instructs to file a WC claim
- Refuses, says no time for paperwork
- Will use personal group insurance

TASB™ RISK FUND | 50 YEARS STRONG

Employee Strains Back Moving a Box of Books

- Informs co-worker
- Co-worker instructs to file a WC claim = **CORRECT**
- Refuses, says no time for paperwork = **WRONG**
- Will use personal group insurance = **WRONG**

TASB™ RISK FUND | 50 YEARS STRONG

“Reasonable Report”

- Is someone an employee is reasonably expected to report to

Example: Supervisors, Nurses, Secretaries, Principals, Managers, Leads, etc.

“Reasonable Report”

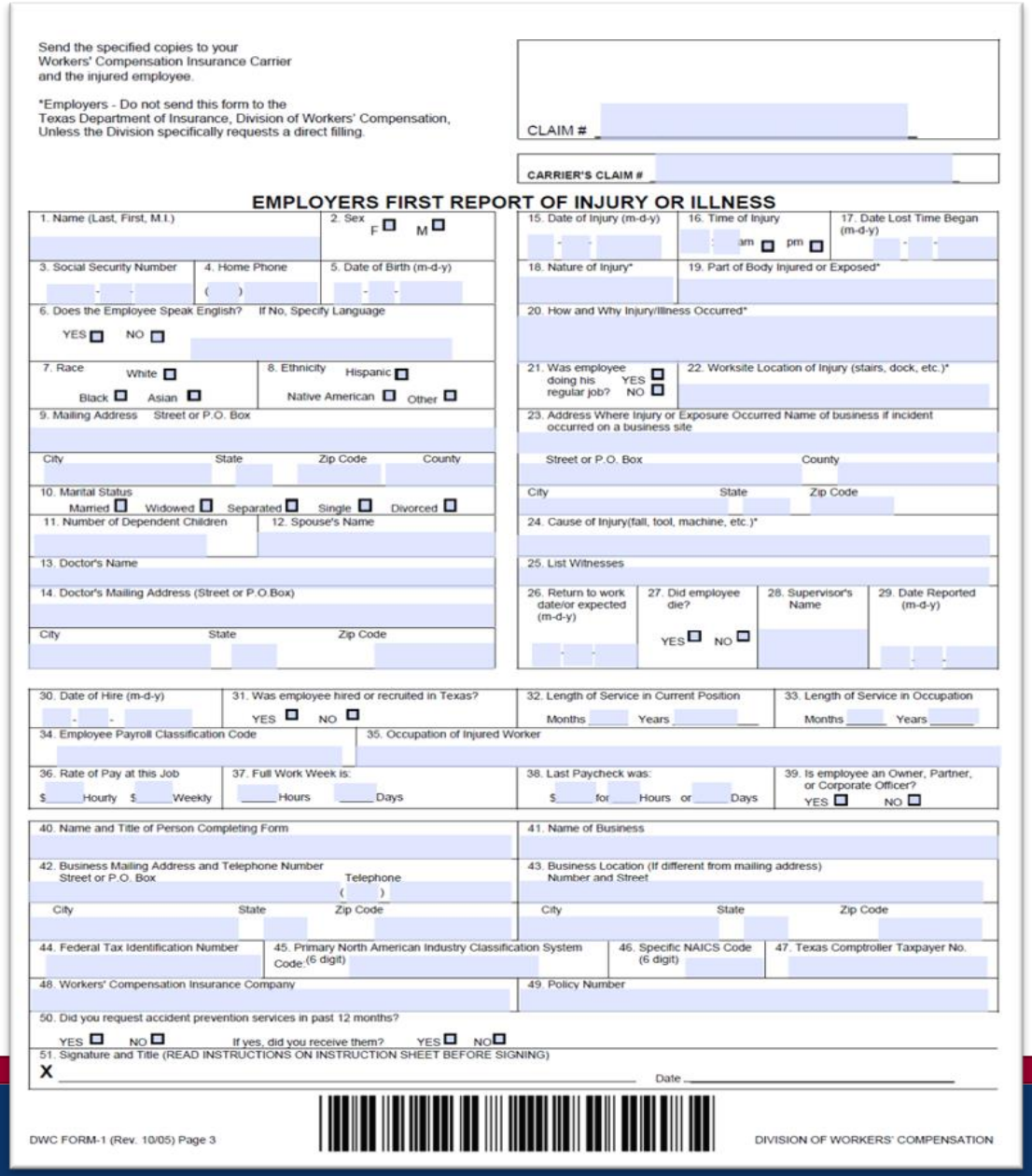
- You know
- Report
- With or without employee’s consent

TASB™ RISK FUND | 50 YEARS STRONG

Employer Responsibilities (Report to State)

- More than 1 day lost time (even if paid)
- Medical Care
- Occupational Injury/Illness

Due by 8th day of above



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 | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language YES NO | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box | City State Zip Code County | 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

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

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 | City State Zip Code | 43. Business Location (If different from mailing address) Number and Street | 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

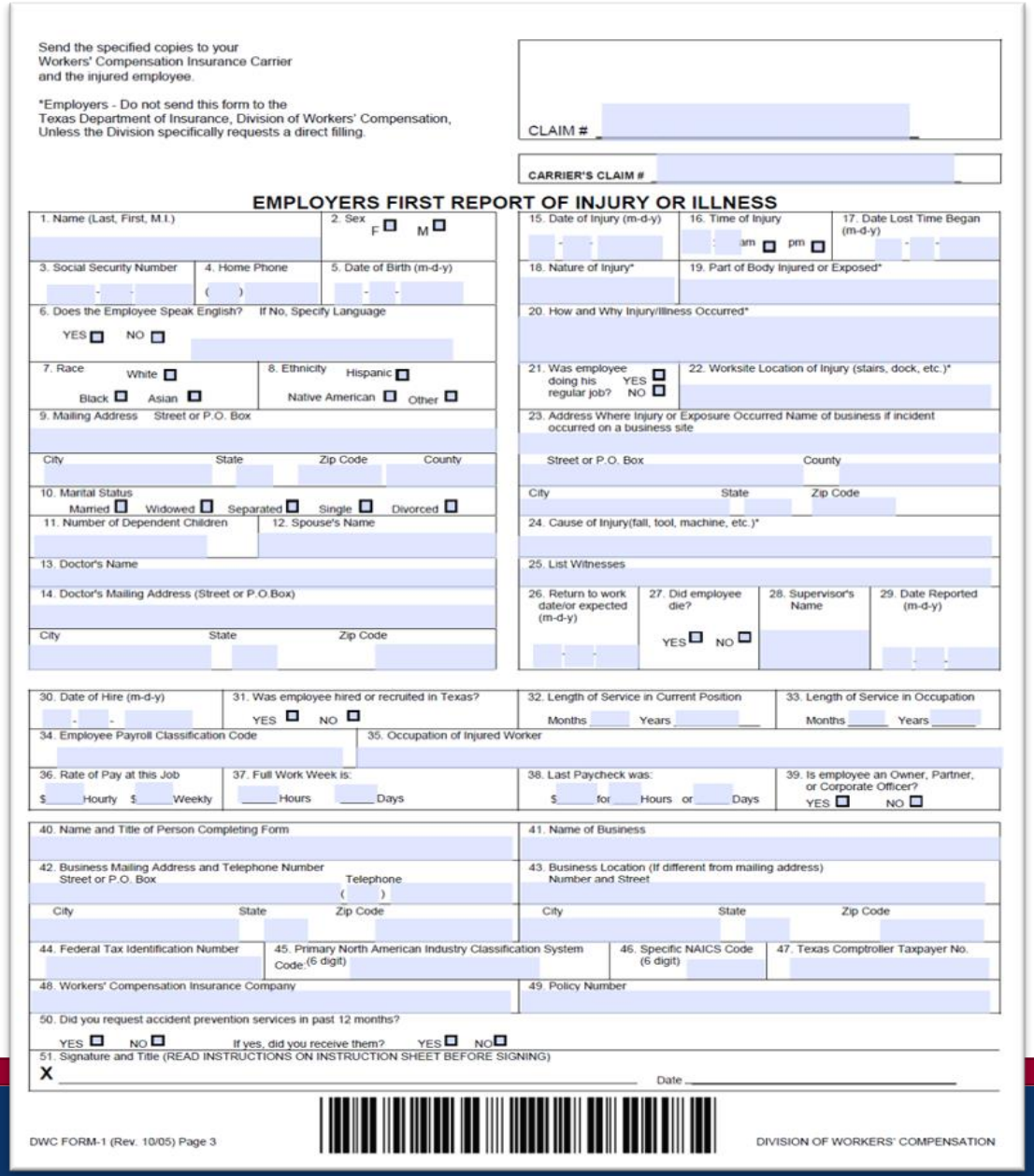
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

DWC FORM-1 (Rev. 10/05) Page 3 DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

Employer Responsibilities

- Create the Record
- Copy employee with rights and responsibilities



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 | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language YES NO | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

City State Zip Code County | Street or P.O. Box County

10. Marital Status Married Widowed Separated Single Divorced | City State Zip Code

11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)*

13. Doctor's Name | 25. List Witnesses

14. Doctor's Mailing Address (Street or P.O.Box) | 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)

City State Zip Code

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)

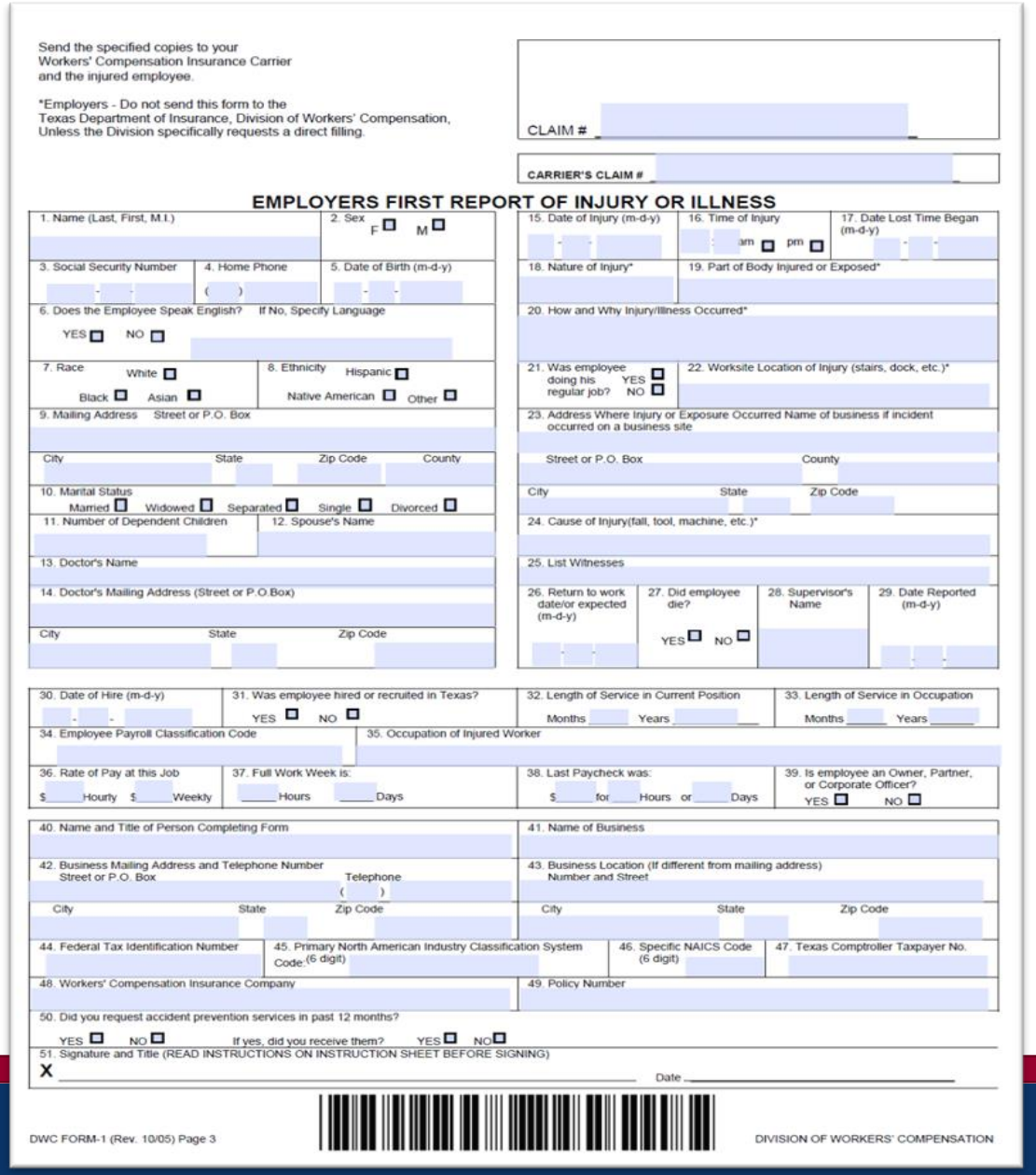
X _____ Date _____

DWC FORM-1 (Rev. 10/05) Page 3 DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

First Report of Injury/Illness (FROI)

- Completing a record does not mean compensability



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 | 15. Date of Injury (m-d-y) | 16. Time of Injury am pm | 17. Date Lost Time Began (m-d-y)

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y) | 18. Nature of Injury* | 19. Part of Body Injured or Exposed*

6. Does the Employee Speak English? If No, Specify Language YES NO | 20. How and Why Injury/Illness Occurred*

7. Race White Black Asian | 8. Ethnicity Hispanic Native American Other | 21. Was employee doing his regular job? YES NO | 22. Worksite Location of Injury (stairs, dock, etc.)*

9. Mailing Address Street or P.O. Box | 23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

City State Zip Code County | Street or P.O. Box County

10. Marital Status Married Widowed Separated Single Divorced | City State Zip Code

11. Number of Dependent Children | 12. Spouse's Name | 24. Cause of Injury(fall, tool, machine, etc.)*

13. Doctor's Name | 25. List Witnesses

14. Doctor's Mailing Address (Street or P.O.Box) | 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)

City State Zip Code

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

DWC FORM-1 (Rev. 10/05) Page 3 DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

First Report of Injury

- State requires 5 years from last date of year it was created
- Must have a separate folder (FROIs)

TASB™ RISK FUND | 50 YEARS STRONG

Compensability Exceptions

- Purposely harmed themselves
- Injured while engaging in “horseplay” or while intoxicated
- Injured outside of work while voluntarily participating in an off-duty sports or social event

TASB™ RISK FUND | 50 YEARS STRONG

Roles Defined

Adjuster has a task

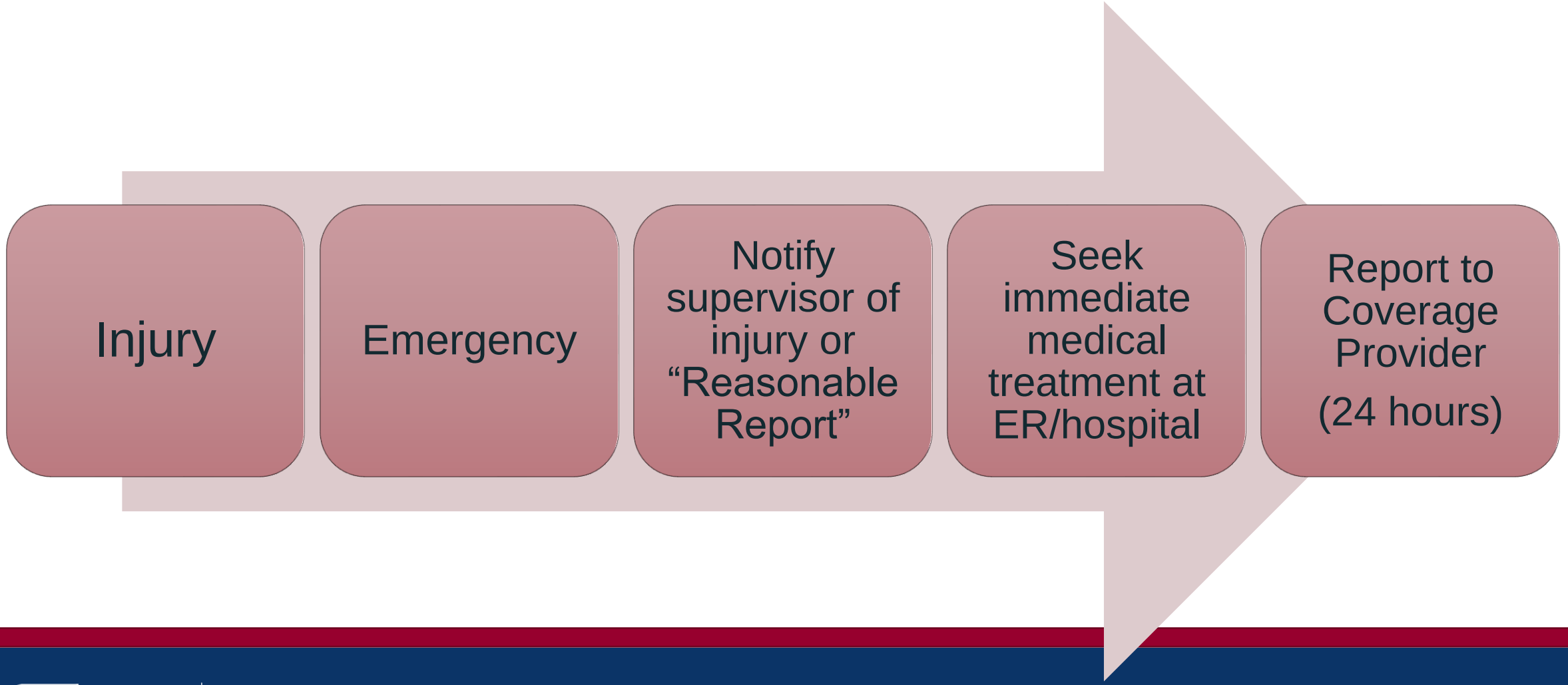
Employer has a responsibility

Injured worker has a part to play

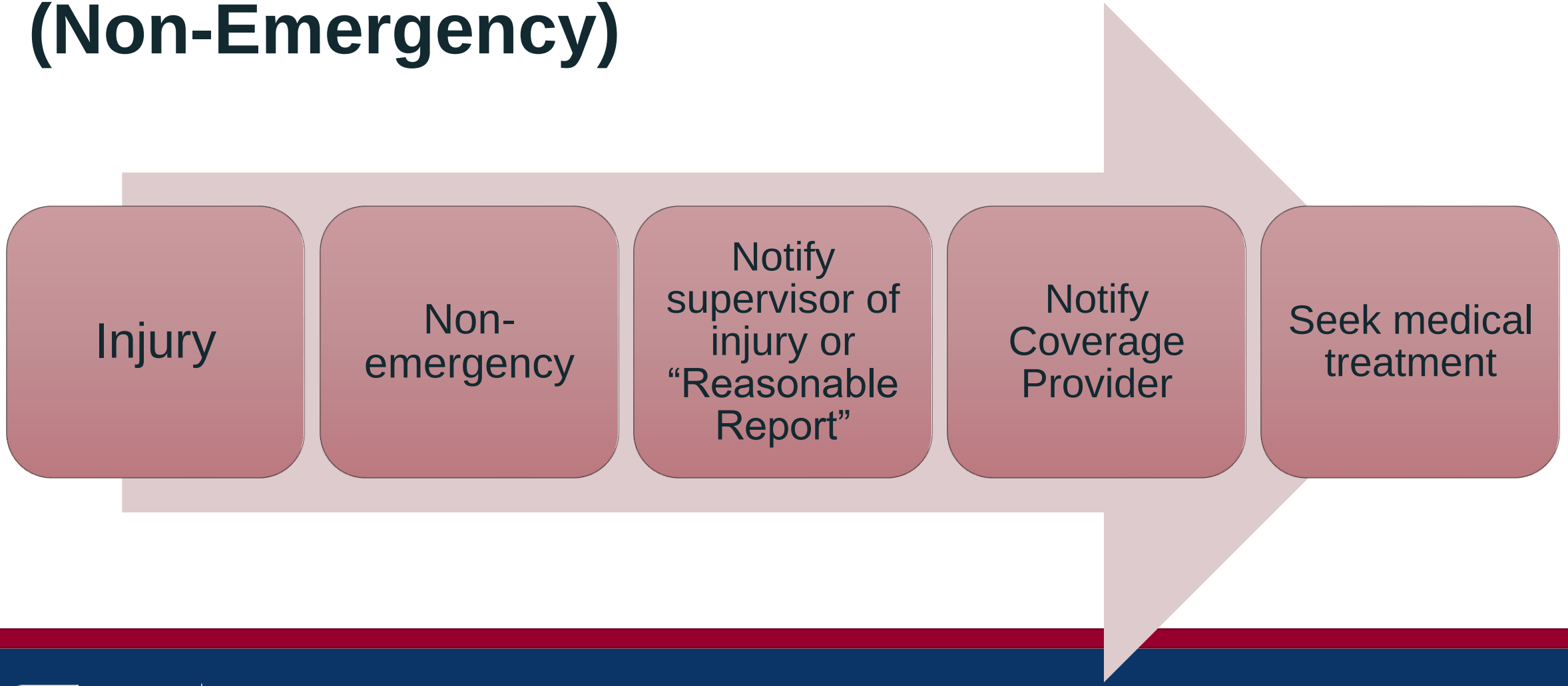
TASB™ RISK FUND | 50 YEARS STRONG

Course of a Work-Related Injury

Course of a Work-Related Injury (Emergency)

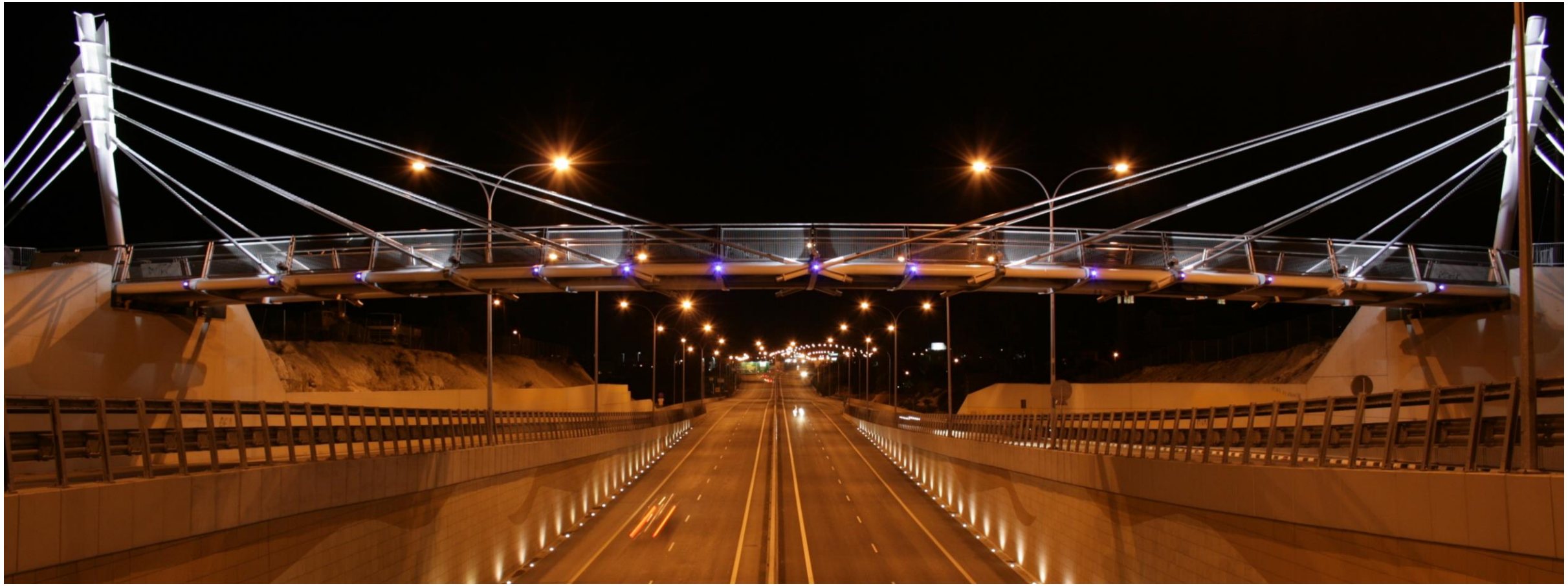


Course of a Work-Related Injury (Non-Emergency)



Unidirectional Claim

Role – Path – Communication



Employer Responsibilities

- Walk employee through paperwork
- Obtain all detailed information
- Stay in contact

Adjuster Responsibilities

- Determine if reported timely
- If employee in course & scope
- Employee at greater risk

Injured Worker Responsibilities

- Promptly report a work-related injury
- Seek medical attention, where necessary
- Cooperate with carrier and investigation

Medical Provider Responsibilities

- Management and coordination of health care for compensable injury
- Communicate about the injured employee's ability to work or any work restrictions
- Provide a DWC 73, Work Status form

Work Status Form DWC 73

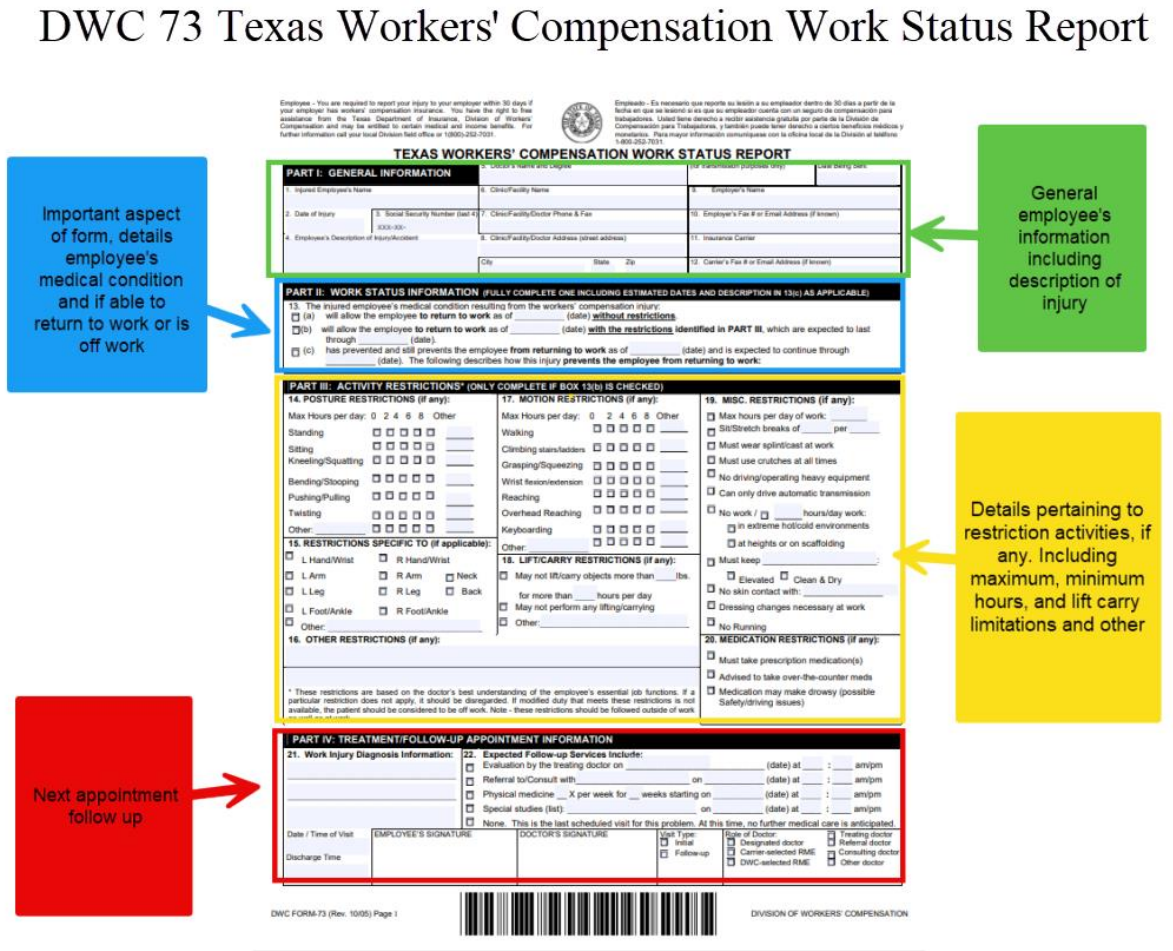


Image source: https://www.tdi.texas.gov/wc/index.html

Failure to Report

- Can result in fines
- Cover a claim that should have been rejected

Workers' Compensation Benefits

- **Temporary Income Benefits (TIBs)**
- Impairment Income Benefits (IIBs)
- Supplemental Income Benefits (SIBs)
- Lifetime Income Benefits (LIBs)

TASB™ RISK FUND | 50 YEARS STRONG

Workers' Compensation Benefits

- Medical Care/Surgeries/Hospital Stay
- Prescription Medications
- Physical Therapy/Rehabilitation
- Medical Equipment/Assistive Devices

TASB™ RISK FUND | 50 YEARS STRONG

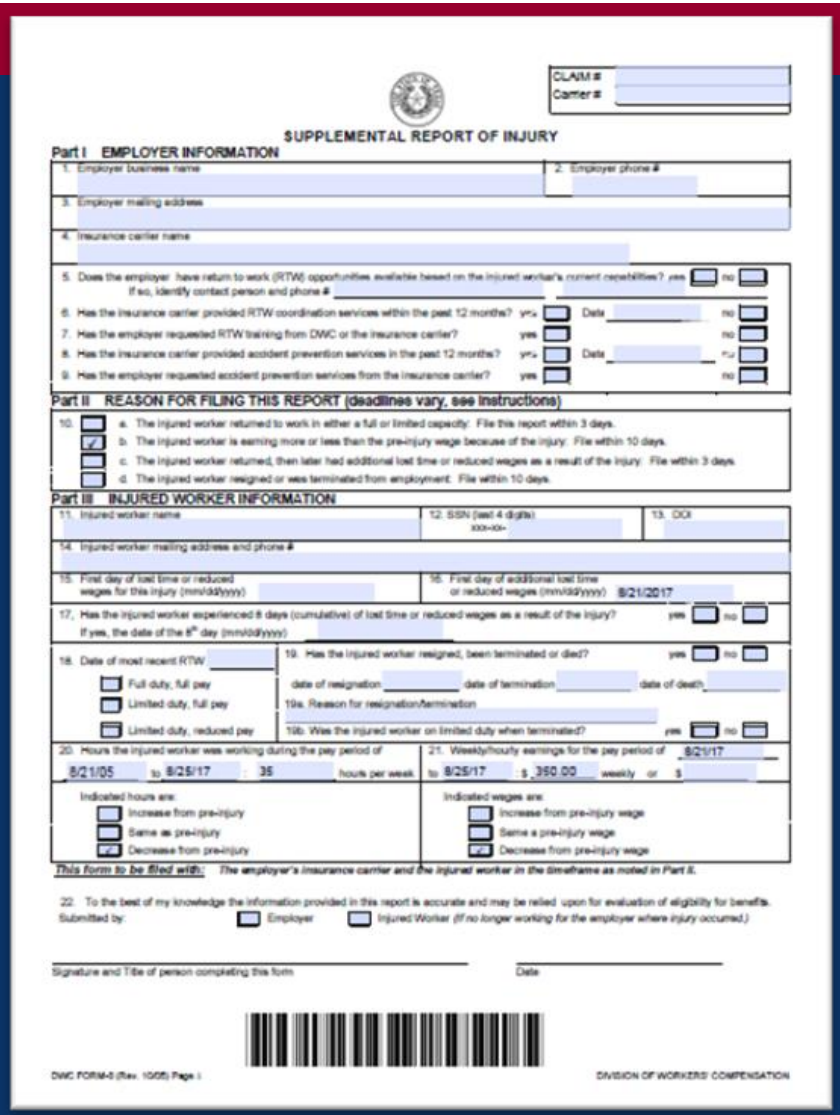
Workers' Compensation Benefits

- Burial Benefits
- Death Benefits

TASB™ RISK FUND | 50 YEARS STRONG

DWC 6 Supplemental Report of Injury

- Employee starts/resumes lost time
- Due by 3rd day



CLAIM #
Carrier #

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes no
If so, identify contact person and phone #
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes Date no
7. Has the employer requested RTW training from DWC or the insurance carrier? yes no
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes Date no
9. Has the employer requested accident prevention services from the insurance carrier? yes no

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
d. The injured worker resigned or was terminated from employment. File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) xxx-xx-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy) 8/21/2017
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes no
If yes, the date of the 8th day (mm/dd/yyyy)
18. Date of most recent RTW
Full duty, full pay
Limited duty, full pay
Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes no
date of resignation date of termination date of death
19a. Reason for resignation/termination
19b. Was the injured worker on limited duty when terminated? yes no
20. Hours the injured worker was working during the pay period of 8/21/05 to 8/25/17 35 hours per week
Indicated hours are:
Increase from pre-injury
Same as pre-injury
Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of 8/21/17 to 8/25/17 $ 350.00 weekly or $
Indicated wages are:
Increase from pre-injury wage
Same a pre-injury wage
Decrease from pre-injury wage

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker *(If no longer working for the employer where injury occurred.)*

Signature and Title of person completing this form
Date

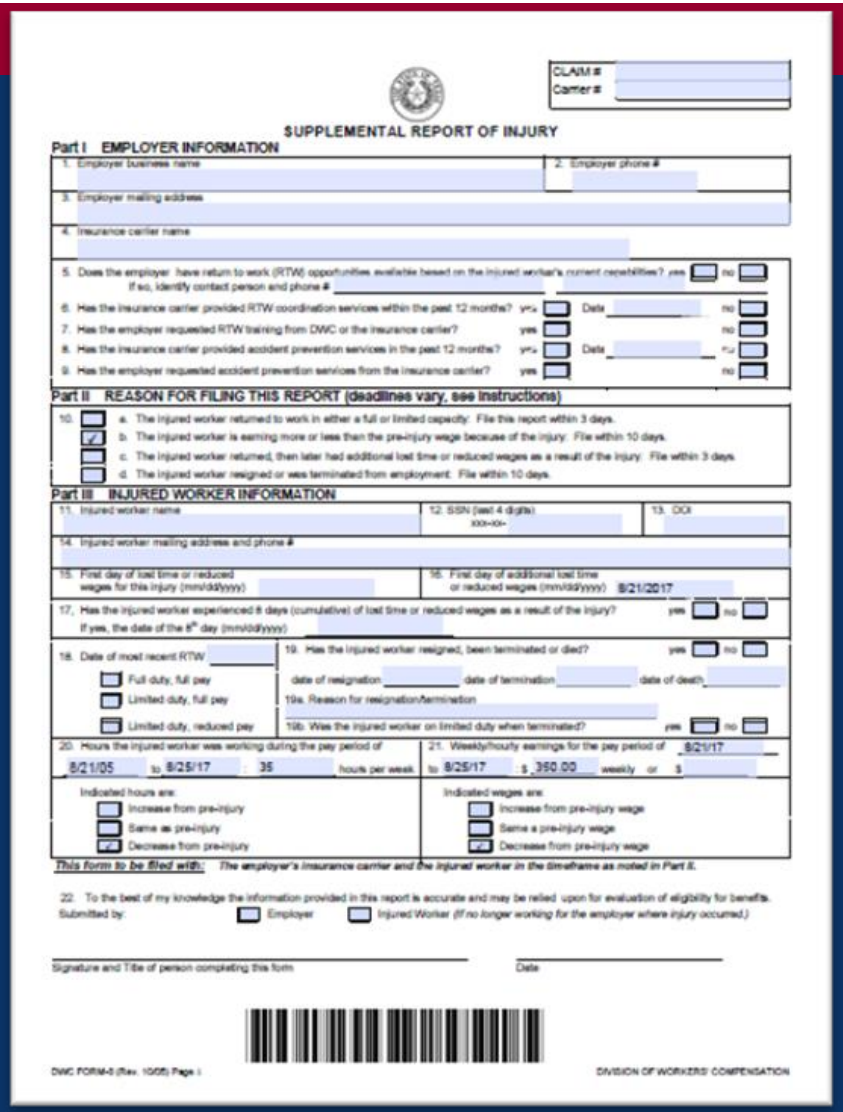
DWC FORM-6 (Rev. 10/05) Page 1
DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

TASB™ RISK FUND | 50 YEARS STRONG

DWC 6 Supplemental Report of Injury

- Reduced time or pay
- Terminate, retire, resign
- Due by 3rd day



SUPPLEMENTAL REPORT OF INJURY

CLAIM #
Carrier #

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes no
If so, identify contact person and phone #
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes Date no
7. Has the employer requested RTW training from DWC or the insurance carrier? yes no
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes Date no
9. Has the employer requested accident prevention services from the insurance carrier? yes no

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. a. The injured worker returned to work in either a full or limited capacity. File this report within 3 days.
b. The injured worker is earning more or less than the pre-injury wage because of the injury. File within 10 days.
c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury. File within 3 days.
d. The injured worker resigned or was terminated from employment. File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) XXX-XX-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy) 8/21/2017
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes no
If yes, the date of the 8th day (mm/dd/yyyy)
18. Date of most recent RTW
Full duty, full pay
Limited duty, full pay
Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes no
date of resignation date of termination date of death
19a. Reason for resignation/termination
19b. Was the injured worker on limited duty when terminated? yes no
20. Hours the injured worker was working during the pay period of 8/21/05 to 8/25/17 35 hours per week
Indicated hours are:
Increase from pre-injury
Same as pre-injury
Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of 8/21/17 to 8/25/17 $ 350.00 weekly or $
Indicated wages are:
Increase from pre-injury wage
Same a pre-injury wage
Decrease from pre-injury wage

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker *(If no longer working for the employer where injury occurred.)*

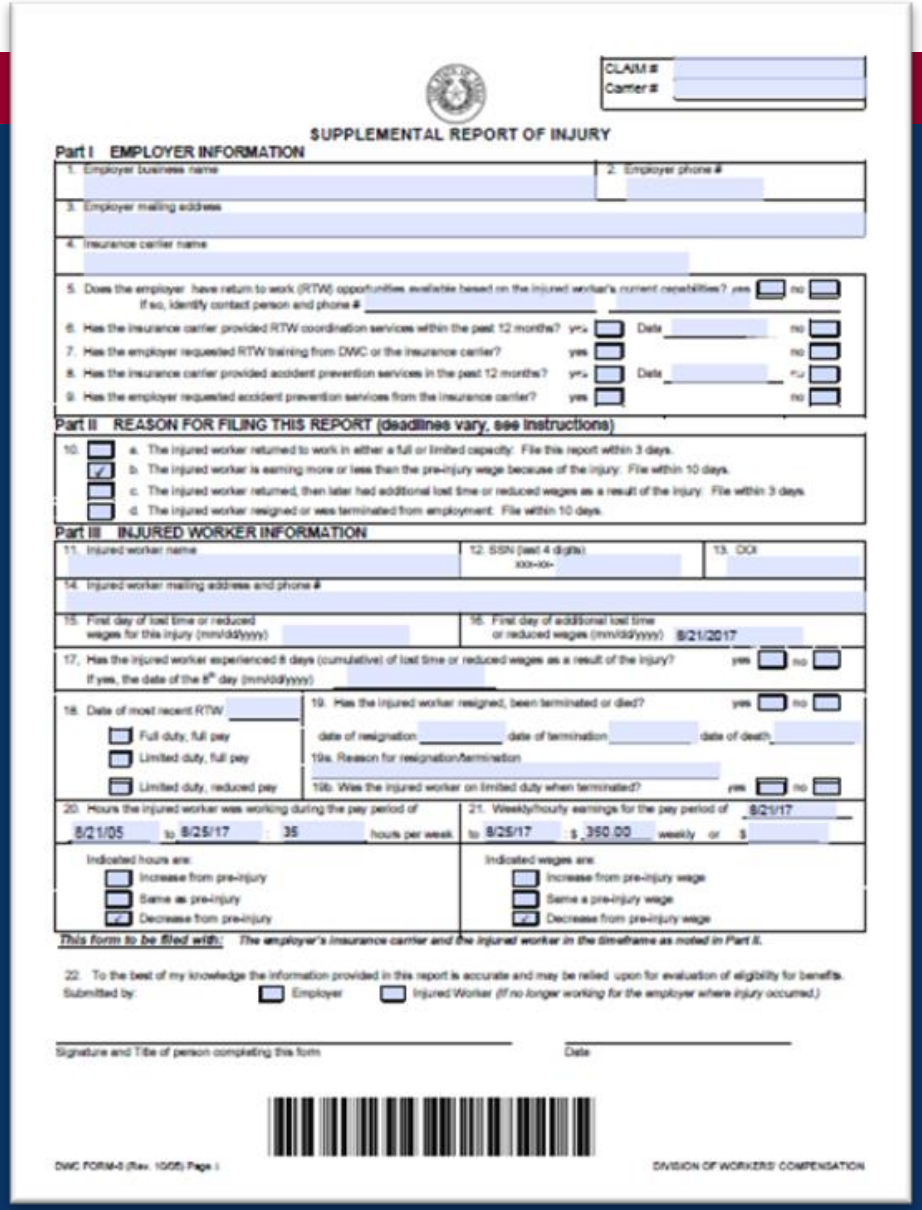
Signature and Title of person completing this form
Date

DWC FORM-6 (Rev. 10/05) Page 1
DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

DWC 6 Supplemental Report of Injury

- Copy employee on every DWC 6 completed



SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name
2. Employer phone #
3. Employer mailing address
4. Insurance carrier name
5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes no
If so, identify contact person and phone #
6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes Date no
7. Has the employer requested RTW training from DWC or the insurance carrier? yes no
8. Has the insurance carrier provided accident prevention services in the past 12 months? yes Date no
9. Has the employer requested accident prevention services from the insurance carrier? yes no

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name
12. SSN (last 4 digits) xxx-xx-
13. DOI
14. Injured worker mailing address and phone #
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)
16. First day of additional lost time or reduced wages (mm/dd/yyyy) 8/21/2017
17. Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes no
If yes, the date of the 8th day (mm/dd/yyyy)
18. Date of most recent RTW
Full duty, full pay
Limited duty, full pay
Limited duty, reduced pay
19. Has the injured worker resigned, been terminated or died? yes no
date of resignation date of termination date of death
19a. Reason for resignation/termination
19b. Was the injured worker on limited duty when terminated? yes no
20. Hours the injured worker was working during the pay period of 8/21/05 to 8/25/17 35 hours per week
Indicated hours are:
Increase from pre-injury
Same as pre-injury
Decrease from pre-injury
21. Weekly/hourly earnings for the pay period of 8/21/17 to 8/25/17 $ 350.00 weekly or $
Indicated wages are:
Increase from pre-injury wage
Same a pre-injury wage
Decrease from pre-injury wage

This form to be filed with: The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: Employer Injured Worker *(If no longer working for the employer where injury occurred.)*

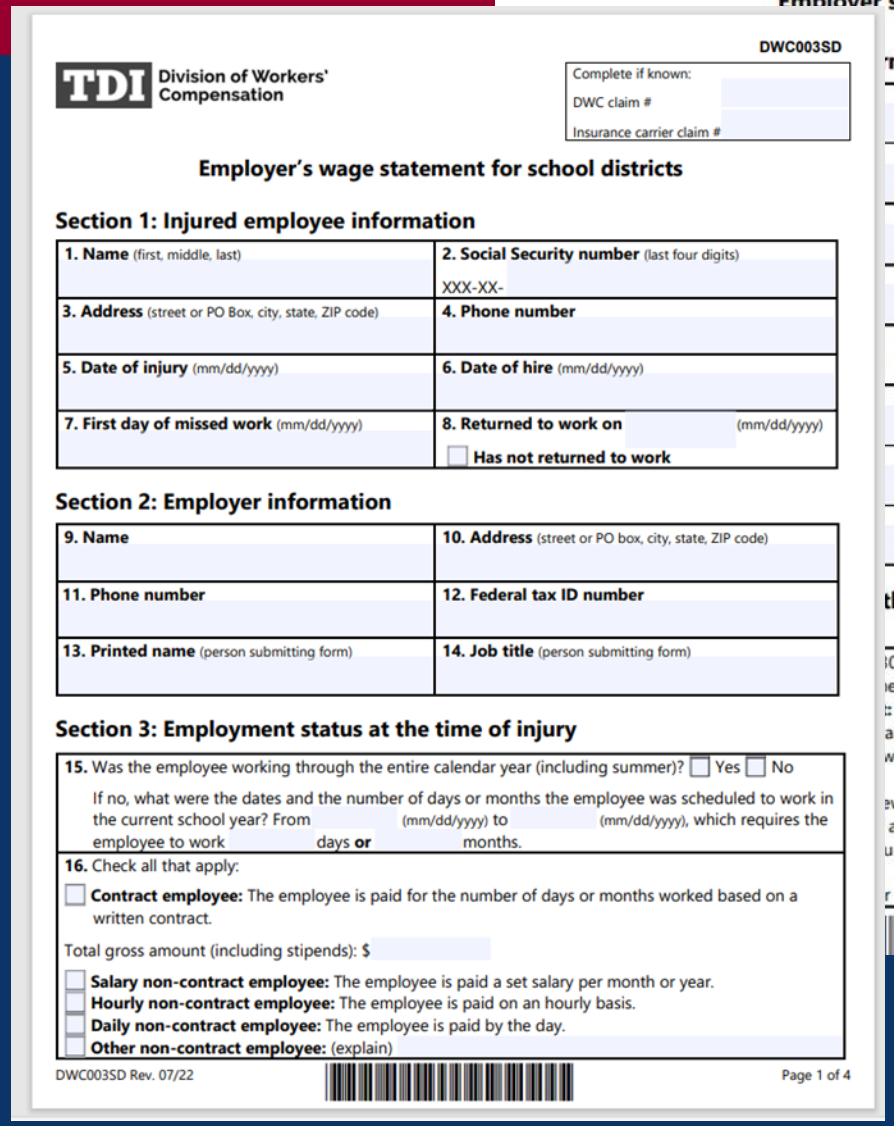
Signature and Title of person completing this form
Date

DWC FORM-6 (Rev. 10/05) Page 1
DIVISION OF WORKERS' COMPENSATION

Image source: https://www.tdi.texas.gov/wc/index.html

DWC 3 & DWC 3SD Wage Statement

- Employee resigns, terminated, or retires
- Due by 10th day



DWC003SD

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's wage statement for school districts

Section 1: Injured employee information

1. Name (first, middle, last)	**2. Social Security number** (last four digits) XXX-XX-
3. Address (street or PO Box, city, state, ZIP code)	**4. Phone number**
5. Date of injury (mm/dd/yyyy)	**6. Date of hire** (mm/dd/yyyy)
7. First day of missed work (mm/dd/yyyy)	**8. Returned to work on** (mm/dd/yyyy) ☐ **Has not returned to work**

Section 2: Employer information

9. Name	**10. Address** (street or PO box, city, state, ZIP code)
11. Phone number	**12. Federal tax ID number**
13. Printed name (person submitting form)	**14. Job title** (person submitting form)

Section 3: Employment status at the time of injury

15. Was the employee working through the entire calendar year (including summer)? ☐ Yes ☐ No

If no, what were the dates and the number of days or months the employee was scheduled to work in the current school year? From (mm/dd/yyyy) to (mm/dd/yyyy), which requires the employee to work days **or** months.

16. Check all that apply:

☐ **Contract employee:** The employee is paid for the number of days or months worked based on a written contract.

Total gross amount (including stipends): $

☐ **Salary non-contract employee:** The employee is paid a set salary per month or year.
☐ **Hourly non-contract employee:** The employee is paid on an hourly basis.
☐ **Daily non-contract employee:** The employee is paid by the day.
☐ **Other non-contract employee:** (explain)

DWC003SD Rev. 07/22

Page 1 of 4

DWC003

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's wage statement

rmation

	2. Social Security number (last four digits) XXX-XX-
	4. Phone number
	6. Date of hire (mm/dd/yyyy)
	8. Returned to work on (mm/dd/yyyy) ☐ **Has not returned to work**
	10. Address (street or PO box, city, state, ZIP code)
	12. Federal tax ID number
	14. Job title (person submitting form)

the time of injury

0 hours or more per week.
e employee regularly works less than 30 hours per week.
: The employee's work history for the 12-month period and full-time work.
work to meet the employer's needs during certain times of

ew skilled trade by on-the-job training and studies.
age and not married or emancipated by court action.
urse of study (such as high school, college, or technical

r the job they were originally hired to do.

Page 1 of 4

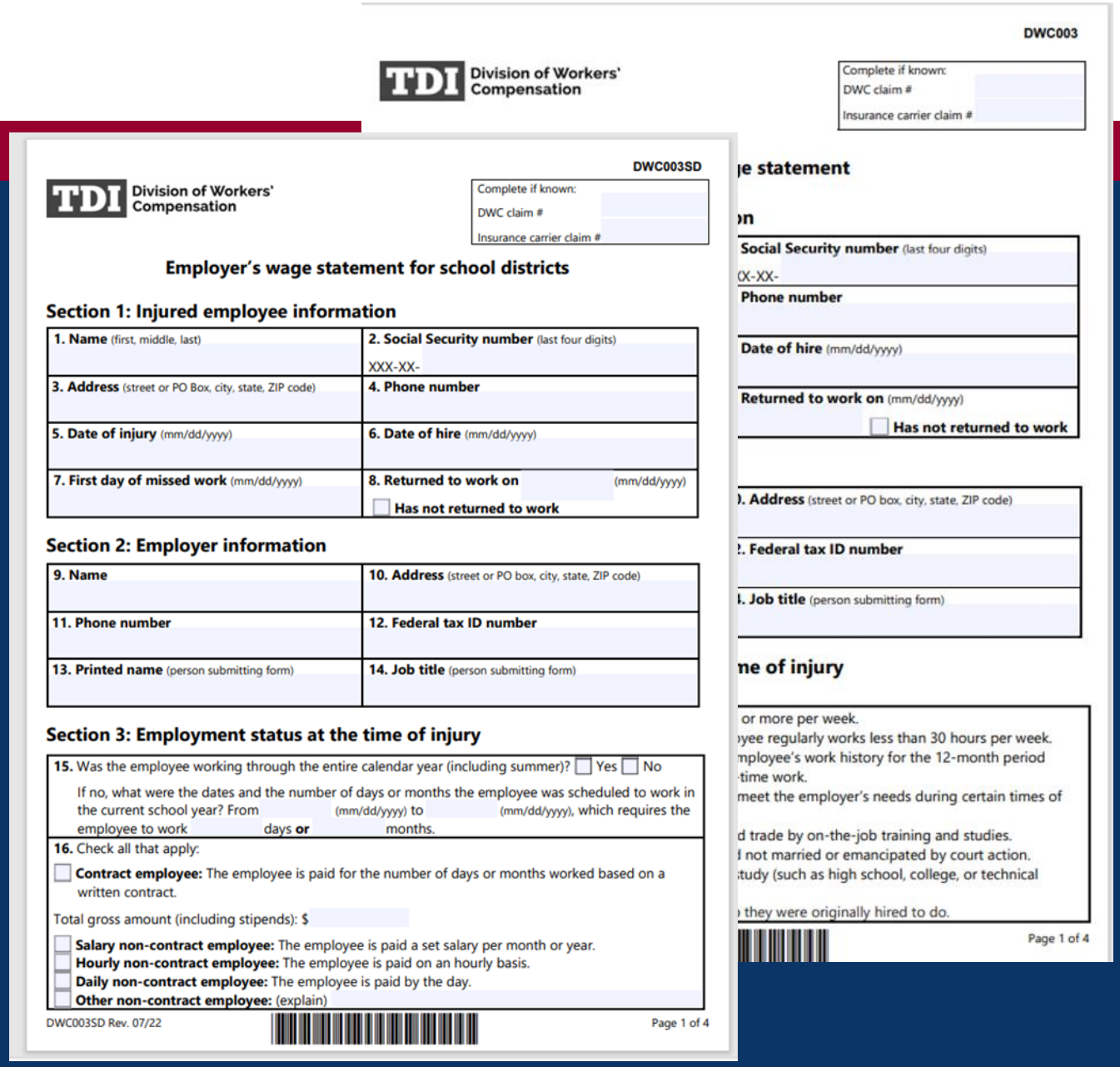
Image source: https://www.tdi.texas.gov/wc/index.html

TASB™ RISK FUND | 50 YEARS STRONG

DWC 3 & DWC 3SD Wage Statement

Due 30th day from the occurrence of any of the following:

- 8th day of disability
- As soon as requested
- Death of employee



DWC003

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

DWC003SD

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's wage statement for school districts

Section 1: Injured employee information

1. Name (first, middle, last)	**2. Social Security number** (last four digits) XXX-XX-
3. Address (street or PO Box, city, state, ZIP code)	**4. Phone number**
5. Date of injury (mm/dd/yyyy)	**6. Date of hire** (mm/dd/yyyy)
7. First day of missed work (mm/dd/yyyy)	**8. Returned to work on** (mm/dd/yyyy) ☐ **Has not returned to work**

Section 2: Employer information

9. Name	**10. Address** (street or PO box, city, state, ZIP code)
11. Phone number	**12. Federal tax ID number**
13. Printed name (person submitting form)	**14. Job title** (person submitting form)

Section 3: Employment status at the time of injury

15. Was the employee working through the entire calendar year (including summer)? ☐ Yes ☐ No

If no, what were the dates and the number of days or months the employee was scheduled to work in the current school year? From (mm/dd/yyyy) to (mm/dd/yyyy), which requires the employee to work days **or** months.

16. Check all that apply:

☐ **Contract employee:** The employee is paid for the number of days or months worked based on a written contract.

Total gross amount (including stipends): $

☐ **Salary non-contract employee:** The employee is paid a set salary per month or year.
☐ **Hourly non-contract employee:** The employee is paid on an hourly basis.
☐ **Daily non-contract employee:** The employee is paid by the day.
☐ **Other non-contract employee:** (explain)

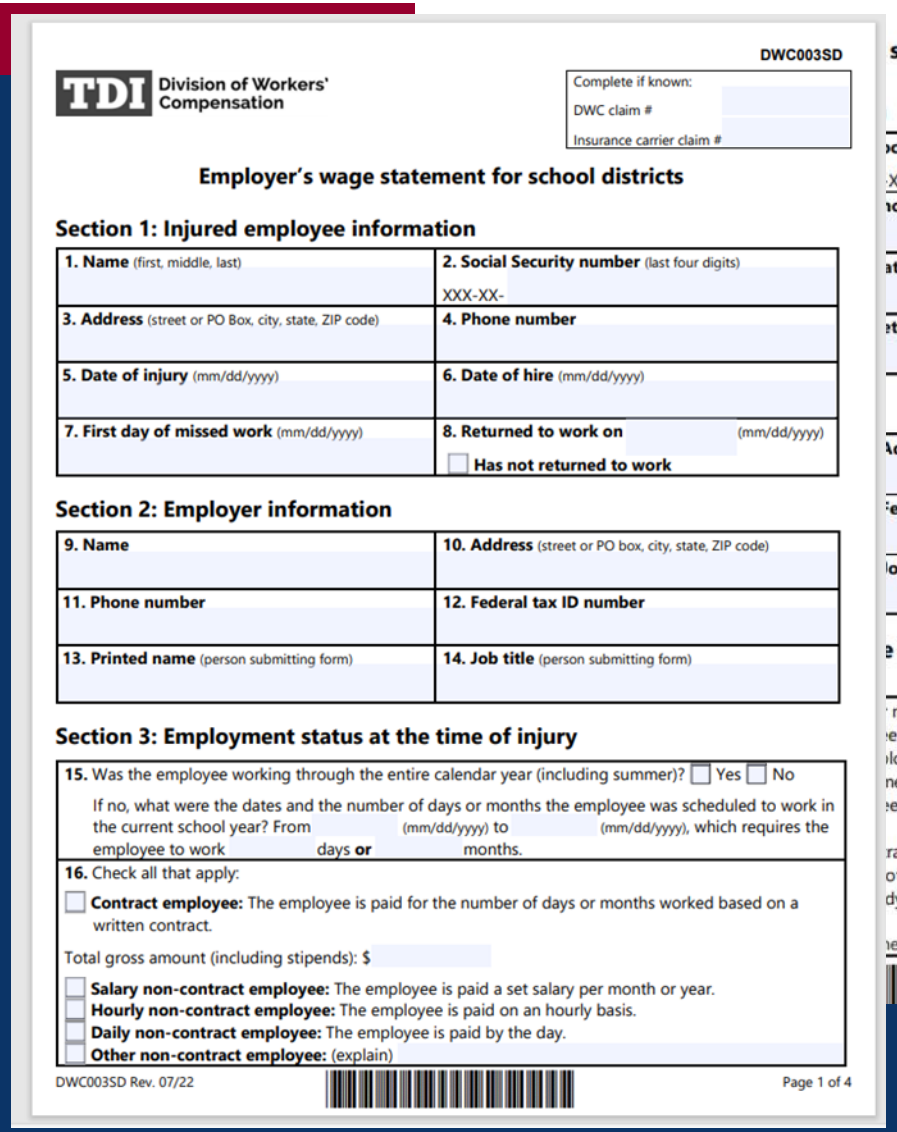
DWC003SD Rev. 07/22

Page 1 of 4

Image source: https://www.tdi.texas.gov/wc/index.html

DWC 3 & DWC 3SD Wage Statement

- Incorrect statements are returned for correction
- Copy employee and properly sign every wage statement



DWC003SD

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

Employer's wage statement for school districts

Section 1: Injured employee information

1. Name (first, middle, last)	**2. Social Security number** (last four digits) XXX-XX-
3. Address (street or PO Box, city, state, ZIP code)	**4. Phone number**
5. Date of injury (mm/dd/yyyy)	**6. Date of hire** (mm/dd/yyyy)
7. First day of missed work (mm/dd/yyyy)	**8. Returned to work on** (mm/dd/yyyy) ☐ Has not returned to work

Section 2: Employer information

9. Name	**10. Address** (street or PO box, city, state, ZIP code)
11. Phone number	**12. Federal tax ID number**
13. Printed name (person submitting form)	**14. Job title** (person submitting form)

Section 3: Employment status at the time of injury

15. Was the employee working through the entire calendar year (including summer)? ☐ Yes ☐ No

If no, what were the dates and the number of days or months the employee was scheduled to work in the current school year? From (mm/dd/yyyy) to (mm/dd/yyyy), which requires the employee to work days **or** months.

16. Check all that apply:

☐ **Contract employee:** The employee is paid for the number of days or months worked based on a written contract.

Total gross amount (including stipends): $

☐ **Salary non-contract employee:** The employee is paid a set salary per month or year.
☐ **Hourly non-contract employee:** The employee is paid on an hourly basis.
☐ **Daily non-contract employee:** The employee is paid by the day.
☐ **Other non-contract employee:** (explain)

DWC003SD Rev. 07/22

Page 1 of 4

DWC003

TDI Division of Workers' Compensation

Complete if known:
DWC claim #
Insurance carrier claim #

statement

cial Security number (last four digits)
XX-
hone number
ate of hire (mm/dd/yyyy)
eturned to work on (mm/dd/yyyy)
☐ Has not returned to work

Address (street or PO box, city, state, ZIP code)
ederal tax ID number
ob title (person submitting form)

e of injury

more per week.
e regularly works less than 30 hours per week.
loyee's work history for the 12-month period
ne work.
et the employer's needs during certain times of

rade by on-the-job training and studies.
ot married or emancipated by court action.
dy (such as high school, college, or technical

ey were originally hired to do.

Page 1 of 4

Image source: https://www.tdi.texas.gov/wc/index.html

Failure To Timely Submit Can Cost

Managing Claims

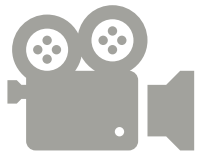
Best Practices

Know Your Team

TASB™ RISK FUND | 50 YEARS STRONG

The Investigation Process

Updated email addresses and phone numbers of injured worker and any witnesses



Any available video

Photos, if necessary

What’s the plan?

Have a Plan

01

Have a Contact List

02

Important*

Back-up Claim Reporting

03

Establish Protocols

04

Share Information

TASB™ RISK FUND | 50 YEARS STRONG

Tools

1

Establish clear policies

2

Train employees and “Reasonable Reports”

3

Create “Injury Kits”

TASB™ RISK FUND | 50 YEARS STRONG

Helpful Tips

- Distribute injury toolkit, use intranet or digital form
- Newsletters
- Continuously remind

Questions?

TASB™ RISK FUND

50 YEARS STRONG

Thank you!

Jennifer Ruedas
WC Claims Adjuster
512-505-2849
Jennifer.Ruedas@tasb.org

Adriana Talbot
WC Program Consultant
512-505-1054
Adriana.Talbot@tasb.org

TASB™ RISK FUND | 50 YEARS STRONG