ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Worker's Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Worker's Compensation Law. Please feel free to call our office with any questions you may have regarding your Worker's Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with to accomplish these goals.

You, the employer, are a vital part of making this happen. Listed below are some things you can do:

1. Report all work-related injuries as soon as you are aware of them.
2. You may report all work-related injuries by email at **claims@acaworkcomp.com** , fax to **1-800-988-4722,** or call **1-800-388-6268** for assistance reporting a claim.

After reporting your claim, you can contact NARS at **1-800-315-6090** for further assistance with your claim including:

1. Refer all medical authorization requests to NARS.
2. Communicate with your employee and NARS throughout the claim.
3. Have some light duty work available for restricted duty.
4. Advise NARS when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed. Fillable forms can also be downloaded at https://aiamga.com/workers-compensation/states-covered/.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best regards,

Associated Claims Administrators

TDI Division of Workers' Compensation

Complete if known:

DWC claim #

Insurance carrier claim #

Employer's first report of injury or illness

Part 1: Injured employee information

1. Name (first, middle, last)	2. Address (street or PO box, city, state, ZIP code)		
3. Phone number	4. Email address	5. Social Security number	6. Date of birth
7. Marital status	8. Sex ☐ Female ☐ Male ☐ Other		
9. Spouse's name (first, middle, last)		10. Number of dependent children	
11. Does the employee speak English? ☐ Yes ☐ No If no, specify language			
12. Doctor's name (first, last)	13. Doctor's mailing address (street or PO box, city, state, ZIP code)		

Part 2: Injury information

14. Date of injury or illness (mm/dd/yyyy)	15. Time of injury : ☐ a.m. or ☐ p.m.	16. First day absent from work (mm/dd/yyyy)
17. Supervisor's name (first, last)		18. Date injury reported (mm/dd/yyyy)
19. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, chemical burn. For more than one injury, list the most serious injury.)		20. Body parts affected
21. Describe in detail how and why the injury, illness, or death occurred (Include the events leading up to the injury or illness, state the actual injury, and list the reasons why the accident or injury occurred.)		
22. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)		
23. Was the employee doing their regular job? ☐ Yes ☐ No		
24. Address and name of the location where the injury, exposure, or death occurred (business name, street or PO box, city, state, ZIP code)		
25. List all witnesses (first, last names)		

26. Number of days absent from work, not including the day of injury or the day of return to work

☐ One day or less (work-related illness only) ☐ Two to seven days ☐ Eight days or more

27. Return-to-work date (mm/dd/yyyy)

☐ Actual date or ☐ Expected date

28. Did the employee die? ☐ Yes ☐ No

If yes, provide the date of death. (mm/dd/yyyy)

Part 3: Employment information

29. Date of hire (mm/dd/yyyy)

30. Occupation of injured employee

31. Length of service in current position

Years Months

32. Length of service in current occupation

Years Months

33. Employee payroll classification code

34. Was the employee hired or recruited in Texas?

☐ Yes ☐ No

35. Rate of pay at this job

$ Hourly $ Weekly

36. Full work week is

Hours Days

37. Last paycheck was

$ for Hours or Days

38. Is the employee an owner, partner, or corporate officer? ☐ Yes ☐ No

Part 4: Employer information

39. Name and title of person completing form (first, middle, last, title)

40. Business name

41. Business mailing address (street or PO box, city, state, ZIP code)

42. Phone number

43. Email address

44. Business location (if different from mailing address)

45. Federal employer identification number

46. Primary North American Industry Classification System (NAICS) code (six digits)

47. Specific NAICS code (six digits)

48. Texas comptroller taxpayer number

49. Workers' compensation insurance carrier

50. Policy number

51. Did you request accident prevention services in the past 12 months? ☐ Yes ☐ No

If yes, did you receive them? ☐ Yes ☐ No

Part 5: Certification

52. Certify with your signature:

I certify the information in this form is true and correct.

Signature_____ **Date**_____

FAQ
Employer's first report of injury or illness

Who do I send this form to?
Send this form to your workers' compensation insurance carrier and to the injured employee or the injured employee's representative. Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation (DWC), unless DWC specifically requests it.

When do I need to send this form?
You must send the DWC Form-001 within eight days after:

1. The employee's first day of absence from work due to the injury;
2. You receive notice of occupational disease; or
3. An employee dies.

Why do I need to send this form?
Employers must file this form so the insurance carrier has the information they need to begin the claims process. You may be fined if you fail to send this report without having a good reason (good cause.)

How should I send this form?
You can file the form with the insurance carrier and send it to the injured employee or the injured employee's representative by email, fax, U.S. Postal Service, or personal delivery.

Do I need to keep a copy of this form?
Yes, you should keep a copy of this form to serve as the Employer's Record of Injury required by Texas Labor Code Section 409.006. For more requirements refer to DWC rule 120.2, *Employer's first report of injury and notice of injured employee rights and responsibilities*.

Questions?
Call 800-252-7031, Monday through Friday, 8 a.m. to 5 p.m., Central time.
Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

Note: With few exceptions, on your request, you are entitled to:

- Be informed about the information DWC collects about you.
- Receive and review the information (Government Code Sections 552.021 and 552.023).
- Have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.

Send to workers' compensation carrier:

_____

(Name and fax number of carrier)

CLAIM # _____

CARRIER'S CLAIM # _____

☐ Initial ☐ Amended

EMPLOYER'S WAGE STATEMENT (DWC Form-003)

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the claimant or the claimant's representative, if any. The purpose of the form is to provide the employee's wage information to the carrier for calculating the employee's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury (or the wage a similar employee earned if the employee did not work the full 13-week period). "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.063(c) and Worker's Compensation Rule 120.4 may be assessed an administrative penalty.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed ("filed" means received) with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the employee's eighth day of disability;
(B) the date the employer is notified that the employee is entitled to income benefits;
(C) the date of the employee's death as a result of a compensable injury.

(2) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(3) A subsequent wage statement shall be filed with the carrier, employee, and the employee's representative (if any) within seven days if any information contained on the previous wage statement changes (such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury).

All applicable DWC rules can be found at http://www.tdi.texas.gov/wc/rules/

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, M.I.):	Employer's Business Name:
Employee's Mailing Address (Street or P.O. Box):	Employer's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:	City: State: ZIP Code:
Social Security Number: xxx-xx-	Federal Tax I.D. Number:
Date of Hire: Date of Injury:	Name and Phone # of Person Providing Wage Information:

☐ As of today's date, the employee is not back at work. **OR**
☐ The employee returned to work on _____ and is working:
- ☐ without restriction. **OR**
- ☐ with restrictions and is earning wages of $_____ per week/month (circle one).

NOTE – Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-6) to report changes in Work Status and Post-Injury Earnings.

I HEREBY CERTIFY THAT this wage statement is complete, accurate, and complies with the Texas Workers' Compensation Act and applicable rules, and the listed wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

EMPLOYMENT STATUS AT TIME OF INJURY (Check All That Apply)

☐ **Full-time:** employee who regularly works at least 30 hours per week and whose schedule is comparable to other employees of the company and/or other employees in the same business or vicinity who are considered full-time.

☐ **Seasonal:** employee who as regular course of conduct engages in seasonal or cyclical employment that may or may not be agricultural in nature and that does not continue throughout the year.

☐ **Part-time: Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows the person only worked part-time during that period.

☐ **Part-time: Not Regular Course of Conduct:** employee whose work history for the 12-month period preceding the injury shows part-time and full time work during that period.

☐ **Apprentice:** employee who is learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan.

☐ **Minor:** employee less than 18 years of age and not emancipated by marriage or judicial action who is also an apprentice, trainee or student.

☐ **Student:** employee enrolled in a course of study in high school, college or other institute of higher education or technical training.

☐ **Trainee:** employee undergoing systematic instruction and practice in some art, trade or profession with a view towards proficiency in it.

SAME OR SIMILAR EMPLOYEE?

The wage information on this form is for:

☐ **The Injured Employee OR** ☐ **A Similar Employee** (NOTE – If requested by the Division, the employer shall identify the similar employee whose wages were provided.)

If the employee was not employed for 13 continuous weeks before the date of injury, report the wages of an employee who has training, experience, skills & wages comparable to the injured employee AND who performs services/tasks comparable in nature and in number of hours. **If no similar employee exists, report the limited available wages earned by the injured employee prior to the injury.**

NOTE TO INJURED EMPLOYEE – If you were injured on or after 7/1/02, and had employment with more than one employer on the date of injury, you can provide your insurance carrier with wage information from your other employment for the carrier to include in your AWW and this may affect your benefits. Contact your carrier for additional information or call the Division at (800) 252-7031. You can also read rule 122.5 at http://www.tdi.texas.gov/wc/rules/

WAGE INFORMATION INSTRUCTIONS

Employee Name: Social Security #: Date of Injury:

- The employer shall report all wages **earned in the 13 weeks immediately preceding the date of injury.** If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 3 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34821. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward slightly (up to six days) to line up the reporting timeframes with the employer's natural pay cycle. **However, the employer shall not report wages earned on or after the date of injury.**

- If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. **In all cases, indicate the dates that each period covers.**

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to: hourly, weekly, biweekly, monthly, etc. wages; salary; tips/gratuities; piecework compensation; monetary allowances; bonuses; and commissions. Earnings are reported in the periods they are earned, NOT when they are paid and some (such as bonuses and commissions) need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employee's equipment or for paying helpers or to reimburse for travel expenses. Consider as earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time earned but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	
FROM DATE:														
TO DATE:														TOTALS
# HOURS WORKED:														
GROSS WAGES EARNED:														

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or stipends paid **to allow the employee to purchase the benefits.**

Nonpecuniary Wage Type	Employer Provided Prior To Injury?		Specify Value Or Amount Earned in Each Reported Period For Each Benefit Provided Prior To Injury (Use the same periods as used above)													Will Employer Continue To Provide?		Date Benefit Suspended (if suspended)
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO	
Health Insurance																		
Laundry/ Cleaning																		
Clothing/ Uniforms																		
Lodging/ Housing/																		
Food/ Meals																		
Vehicle/ Fuel																		
Other																		

NOTE: With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.