

CLAIM # _____
 CARRIER'S CLAIM # _____

EMPLOYER'S REPORT FOR REIMBURSEMENT OF VOLUNTARY PAYMENT

1. Employer's Name		13. Employee's Name (Last,First, M.I.)	
2. Employer's Mailing Address (Street or P.O. Box)		14. Employee's Mailing Address (Street or P.O. Box)	
City	State	Zip Code	City State Zip Code
3. Federal Tax I.D. No.		15. Employee's Social Security Number (last four digits)	
4. Date of Injury	5. Date of this Notice	16. Name of Insurance Carrier	
6. Date Lost Time Began	7. Date of Initial Payment	17. Address of Insurance Carrier (Street or P.O. Box)	
8. Amount of Payment \$	9. Number of Weeks Paid	City	State Zip Code
10. From	11. To	18. Address of Insurance Carrier Claims Office (Str. or P.O. Box)	
12. This Payment: <input type="checkbox"/> Initiates Compensation <input type="checkbox"/> Supplements Injured Employee's Income <input type="checkbox"/> Covers Medical Expenses Incurred		City	State Zip Code
		19. Insurance Carrier Representative	

The employer should notify Texas Department of Insurance, Division of Workers' Compensation and the insurance carrier within 14 days after the date of initial payment. An employer who fails to timely file the report of injury or occupational disease as required by Art. 8308-5.05, of the Texas Workers' ompensation Act waives the right to reimbursement of any voluntary payments and may be assessed an administrative penalty, not to exceed \$500.00. If there is a dispute concerning reimbursement of any employer's payments of compensation or medical benefits, the employer may file a subclaim in accordance with Art. 8308.5.08, of the Texas Workers' Compensation Act.

The insurance carrier should reimburse the employer within 30 days after receiving the request and should notify the Texas Department of Insurance, Division of Workers' Compensation within 10 days of payment of the amount and date of the reimbursement.



DWC FORM - 2
(Employer's Report for Reimbursement of Voluntary Payment)

The **employer** is required to file an **Employer's Report for Reimbursement of Voluntary Payment** [Interim DWC FORM - 2 (10/05)] with the DWC and the insurance carrier. The employer waives the right to reimbursement if it fails to notify the Division by filing DWC FORM - 1 (Employer's First Report of Injury or Illness), or did not do so in a timely manner.

The **Employer's Report for Reimbursement of Voluntary Payment** enables an employer who voluntarily begins payment to an injured worker to recoup from the insurance carrier once a determination of compensability has been made. The insurance carrier, once the claim is found to be compensable, should reimburse the employer within 30 days after receiving the request. Initiation of payment to the worker in no way implies admission of compensability, and the worker must be notified that any payments made by the employer will later be deducted from compensation paid by the insurance carrier. Employers who voluntarily begin payment to an injured worker may not recover from the insured if the claim is determined not compensable.

This form will be printed as a 3-part form with the original to the carrier, the second copy to DWC and the third copy for employer's record.

The report is considered filed when personally delivered or postmarked. Send DWC's copy to the **field office handling the claim**.

[Art. 8308-4.06. Certain Employer Payments Reimbursable; Art. 8308-5.05. Employer Report of Injury; Administrative Violation; Art. 8308-5.08. Subclaims, Texas Workers' Compensation Act]

