

REQUEST FOR RECORD CHECK

INSTRUCTIONS: Please carefully read the instructions before completing this form. INCORRECT/INCOMPLETE FORMS WILL BE RETURNED TO REQUESTOR WITHOUT ACTION. PAYMENT MUST ACCOMPANY REQUEST FORM.

I. CLAIMANT IDENTITY. Provide the following information to identify the injured employee

Injured Employee's Name	Injured Employee's Social Security Number
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II. REQUESTOR INFORMATION. Record check information will be sent to the requestor's address shown below.

Requestor	Title		
Firm Name	TWCC/Adjuster Box Number (if applicable)		
Mailing Address	TWCC Account Number (if applicable)		
City, State	ZIP	Telephone Number ()	<input type="checkbox"/> Authorized Legal Representative Statement on File

III. FEES.

Record Checks are \$15.00 for Each Request. Check box if Certification is requested. (\$1 Additional Fee)

IV. REQUESTOR ELIGIBILITY AND NOTARIZATION. The Texas Workers' Compensation Act, Texas Labor Code, Title 5, Section 402.084, limits the release of confidential information in or derived from an employee's claim file to the categories of parties listed below. Please indicate the category of eligibility which qualifies you to receive the information requested. Sign and complete the notarization prior to sending the request to TWCC. Eligibility will be verified. *Please check one box only.*

- | | |
|---|--|
| <input type="checkbox"/> The employee or the employee's legal beneficiary | <input type="checkbox"/> The insurance carrier. Requestor must provide injured employee's date of injury: _____
mo./yr. |
| <input type="checkbox"/> The employee's or the legal beneficiary's representative | <input type="checkbox"/> The Texas Property and Casualty Insurance Guaranty Association, if that association has assumed the obligations of an impaired insurance company |
| <input type="checkbox"/> The employer at the time of injury. Requestor must provide injured employee's period of employment:
_____ mo./yr. to _____ mo./yr. | <input type="checkbox"/> A third party litigant in a lawsuit, in which the cause of action arises from the incident that gave rise to the injury. (COPY OF FIRST PAGE OF PETITION AND STATEMENT OF FACTS THEREIN MUST BE ATTACHED). Requestor must provide injured employee's date of injury: _____
mo./yr. |
| <input type="checkbox"/> The Texas Certified Self-Insurer Guaranty Association established under Subchapter G, Chapter 407, if that association has assumed the obligations of an impaired employer | |

I have read and understood this form and the accompanying instructions. I am entitled to receive the confidential employee information being requested as indicated above. I understand it is a Class A misdemeanor to unlawfully receive, publish, disclose, or distribute confidential claim information in or derived from an employee's claim file. {Texas Labor Code Sections 402.084; 402.086; 402.091}

Signature of Requestor _____ Date _____

State of _____ *

County of _____ *

Before me on the above date personally appeared, _____, who after first being sworn, said the statements contained in this request are true.

Signed _____

Notary Public, State of _____ My Commission Expires _____