TEXAS WORKERS' COMPENSATION COMMISSION
4000 South IH-35, Southfield Building
Austin, Texas 78704

TWCC # ____________________

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
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: ☐ Initiates Compensation ☐ Supplements Injured Employee's Income ☐ Covers Medical Expenses Incurred		City State Zip Code 19. Insurance Carrier Representative

The employer should notify Texas Workers' Compensation Commission 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' Compensation 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 Workers' Compensation Commission within 10 days of payment of the amount and date of the reimbursement.