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

TWCC# _____

Carrier's Claim # _____

# EMPLOYER'S CONTEST OF COMPENSABILITY

| | | |
|---|---|---|
| 1. Employee's Name (Last, First, M.I.) | 4. Employer's Name (Last, First, M.I.) | |
| | 5. Employer's Mailing Address (Street or P.O. Box) | |
| 2. Social Security Number<br>- - | City State Zip Code | |
| 3. Date of Injury<br>- - | 6. Employer's Telephone No.<br>( ) | 7. Insurance Carrier |

**In accordance with Art. 8308-5.10 of the Texas Workers' Compensation Commission Act, the employer has the right to contest the compensability of an employee's injury if the insurance carrier accepts liability for the payment of benefits.**

8. Provide any relevant facts supporting the reason(s) for contesting compensability.

Employer's Signature _____ Date _____

Title _____