

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: I _____] has workers' compensation

insurance coverage from I _____] protect you in the

Name of Employer
GuideOne Mutual Insurance Co.
Name of commercial insurance company

event of work-related injury or illness. This coverage is effective from I _____].

Effective date of policy

Any injuries or illnesses which occur on or after that will be handled by
I _____]. An employee or a person acting on the

Name of commercial insurance company
GuideOne Mutual Insurance Co.

employee's behalf must notify the employer of an injury or illness not later than the 30th day after the date on which the injury occurs or the date the employee knew or should have known of an illness, unless the Division determines that good cause existed for failure to provide timely notice. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

EMPLOYEE ASSISTANCE: The Division provides free information about how to file a workers' compensation claim. Division staff will explain your rights and responsibilities under the Workers' Compensation Act and assist in resolving disputes about a claim. You can obtain this assistance by contacting your local Division field office or by calling 1-800-252-7031.

SAFETY HOTLINE: The Division has established a 24-hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employer are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact Health and Safety at 1-800-452-9595.

DWC FORM-1
(Employer's First Report of Injury or Illness)

The **employer** is required to file an **Employer's First Report of Injury or Illness** [DWC FORM – 1 (Rev. 10/05)] with the injured worker's insurance carrier, and the injured claimant or the claimant's representative within 8 days after the employee's absence from work or receipt of notice of occupational disease.

The **Employer's First Report of Injury or Illness** provides information on the claimant, employer, insurance carrier and medical practitioner necessary to begin the claims process. Details of the claimant's employment and circumstances surrounding the injury or illness are also requested.

Send the specified copies to your **Worker's Compensation Insurance Carrier** and the injured employee. ***Employers – Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

[Workers' Compensation Rule 120.2]



INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-1)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Article 8308 - 5.05, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM - 1 (Rev. 10-05) to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty not to exceed \$500.00. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Article 8308 - 5.04. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Article 8308 - 7.03 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

- Items 2, 7, 8: Article 8308 - 2.13(e), Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
- Item 4: If no home phone, please provide a phone number where the employee can be reached.
- Items 5, 15, 17, 26, 29, 30: Enter data in month, day, year format. Example: 08-13-54.
- Item 18: List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
- Item 19: List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
- Item 20: Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
- Item 22: State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
- Item 24: List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
- Items 32, 33: Enter date in month-year format. Example: 02-56.
- Item 37: Enter the number of days or hours that make up a full work week for your employees.
- Item 45: Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
- Item 46: For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.



Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIER'S CLAIM # _____

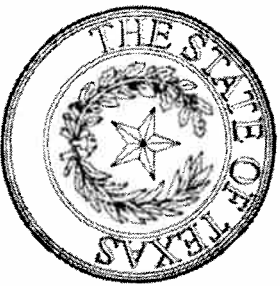
EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>		15. Date of Injury (m-d-y)		16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>		17. Date Lost Time Began (m-d-y)											
3. Social Security Number		4. Home Phone ()		5. Date of Birth (m-d-y)		18. Nature of injury*		19. Part of Body Injured or Exposed*											
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>																			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>			8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>			20. How and Why Injury/Illness Occurred*													
9. Mailing Address Street or P.O. Box					21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>					22. Worksite Location of Injury (stairs, dock, etc.)*									
City		State		Zip Code		County		23. Address Where injury or Exposure Occurred Name of business if incident occurred on a business site											
City		State		Zip Code		County		24. Cause of injury (fall, tool, machine, etc.)*											
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>										25. List Witnesses									
11. Number of Dependent Children					12. Spouse's Name					26. Return to work date/or expected (m-d-y)		27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. Supervisor's Name		29. Date Reported (m-d-y)			
13. Doctor's Name										25. List Witnesses									
14. Doctor's Mailing Address (Street or P.O. Box)										25. List Witnesses									
City		State		Zip Code		25. List Witnesses													

30. Date of Hire (m-d-y)		31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>		32. Length of Service in Current Position Months _____ Years _____		33. Length of Service in Occupation Months _____ Years _____	
34. Employee Payroll Classification Code				35. Occupation of Injured Worker			
36. Rate of Pay at this Job \$ _____ Hourly \$ _____ Weekly		37. Full Work Week is: _____ Hours _____ Days		38. Last Paycheck was: \$ _____ for _____ Hours or _____		39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>	

40. Name and Title of Person Completing Form				41. Name of Business							
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()				43. Business Location (If different from mailing address) Number and Street							
City		State		Zip Code		City		State		Zip Code	
44. Federal Tax Identification Number		45. Primary North American Industry Classification System Code: (6 digit)		46. Specific NAICS Code (6 digit)		47. Texas Comptroller Taxpayer No.					
48. Workers' Compensation Insurance Company				49. Policy Number							
50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>											
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____											





OFFICE OF INJURED EMPLOYEE COUNSEL

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). OIEC is a state agency that is responsible for assisting injured employees with their claim in the workers' compensation system.

You can contact OIEC by calling its toll-free telephone number: 1-866-EZE-OIEC (1-866-393-6432). More information about OIEC and its Ombudsman Program is available at the agency's website (www.oiec.state.tx.us).

OMBUDSMAN PROGRAM

WHAT IS AN OMBUDSMAN?

An Ombudsman is an employee of OIEC who can assist you if you have a dispute with your employer's insurance carrier. An Ombudsman's assistance is free of charge. Each Ombudsman has a workers' compensation adjuster's license and has completed a comprehensive training program designed specifically to assist you with your dispute.

If you have a proceeding scheduled before the Texas Department of Insurance, Division of Workers' Compensation, an Ombudsman can:

- Help you prepare for the proceeding (Benefit Review Conference and/or Contested Case Hearing);
 - Attend the proceeding with you and communicate on your behalf; and
 - Assist you with your appeal and response to insurance carrier appeals.
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EMPLEADORES CON COBERTURA:

Según el Reglamento 110.101(e)(1), el Aviso 6 del Departamento de Seguros de Texas, División de Compensación para Trabajadores, requiere que usted informe a sus empleados acerca de que tiene cobertura de seguros de compensación para trabajadores por medio de una compañía de seguros comercial y debe informar también a los empleados acerca de la línea gratuita de información de la División de Compensación para Trabajadores para obtener información adicional acerca de sus derechos de compensación para trabajadores.

Avisos en Inglés, Español y cualquier otro idioma común para la población de los trabajadores del empleador deben ser puestos a la vista del público y:

- (1) Mostrar muy a la vista en un lugar de la oficina de personal del empleador, si es que la hay;
- (2) Ubicar este aviso en el área de trabajo de tal manera que los empleados lo vean regularmente;
- (3) El título debe ser impreso en tamaño 30, letra negrita de punto, el tema debe ser impreso en tamaño 20, con letra negrita de punto, y el texto, por lo menos en tamaño 19 punto tipo normal.
- (4) Debe contener las palabras exactas como se ha señalado en el Reglamento 110.101 (e)(1).

El aviso que se muestra al reverso de esta página cumple con los requerimientos señalados arriba. El negarse a mostrar o proporcionar esta información, a como es requerido por el reglamento es una violación a la ley y reglamentos de la División.

NO MOSTRAR ESTE LADO

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [_____] tiene cobertura de seguros

de compensación para trabajadores con [_____]

Nombre del empleador
GuideOne Mutual Insurance Co.

Nombre de la compañía de seguros

para protegerlo en caso de una lesión o enfermedad relacionada con su trabajo. Esta cobertura está vigente desde

el [_____] Cualquier lesión o enfermedad,

Fecha en que entra en vigencia la póliza

que ocurra en o a partir de esta fecha será manejada por [_____]

GuideOne Mutual Insurance Co.
Nombre de la compañía de seguros

El empleado o la persona que lo representa debe notificar al empleador cuando el empleado sufre una lesión o enfermedad en el trabajo a no más tardar de treinta (30) días después de que ocurrió la lesión o en la fecha en la que el empleado se enteró o debería de haberse enterado de la enfermedad, al menos que la División determine que existe un buen motivo para que no se haya notificado al empleador dentro del tiempo señalado. Su empleador está obligado a proporcionarle información acerca de la cobertura de seguro de compensación, por escrito cuando usted es contratado o cuando su empleador adquiere o deje de tener cobertura de seguro de compensación para trabajadores.

ASISTENCIA AL EMPLEADO:

La División le proporciona información gratuita sobre como someter un reclamo de compensación para trabajadores. El personal de la División le explicará cuales son sus derechos y responsabilidades bajo la Ley de Compensación para Trabajadores de Texas y le asistirá para resolver disputas relacionadas con su reclamo. Usted puede obtener este tipo de asistencia comunicándose con la oficina local de la División al teléfono 1-800-252-7031.

LÍNEA PARA REPORTAR CONDICIONES INSEGURAS:

La División ha establecido una línea gratuita telefónica que está en servicio las 24 horas del día, para reportar condiciones inseguras en el lugar de trabajo que pudiesen violar las leyes ocupacionales de salud y seguridad. La ley prohíbe que los empleadores suspendan, despidan o discriminen al empleado o empleada porque el o ella, de buena fe reporta una alegada violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al teléfono 1-800-452-9595.