Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

Employer Notice of No Coverage or Termination of Coverage

Online submission available through Employer Online Filings at:
https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp

I. REQUIRED STATEMENTS

1. Statement of No Coverage

☐ The employer named below **DOES NOT HAVE** workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.004.

☐ The employer named below **HAS TERMINATED** workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.007.

Policy terminated effective (mm/dd/yyyy):
Policy number:
Insurance company name:
Insurer informed of termination on (mm/dd/yyyy):
Employees were (will be) notified on (mm/dd/yyyy):

The election selected above is effective from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy). The effective dates cannot exceed a one-year period.

2. Statement of Reportable Injuries or Diseases

Did you have any death, injury that resulted in the injured employee's absence from work for more than one day, or knowledge of an occupational disease since your last *Employer Notice of No Coverage or Termination of Coverage*?

☐ Yes ☐ No If your response is "Yes", you may be required to file a DWC Form-007, *Employer's Report of Non-covered Employee's Occupational Injury or Disease.* (See the Frequently Asked Questions section of this form.)

II. PRIMARY EMPLOYER INFORMATION

3. Employer Business Name	**4. Federal Employer ID Number**
5. Employer Business Mailing Address (Street or PO Box, City, County, State, Zip Code)	
6. Employer Business Type	**7. Six-Digit NAICS Codes**

NOTE: You must provide name, Federal Employer ID number and address of each Texas business location, subsidiary, or separate entity of the primary employer covered by this report. To identify additional locations, submit a DWC Form-205, *Locations of Employer's Business(es).*

III. PERSON PROVIDING INFORMATION

8. Printed Name	**9. Phone Number**
10. Title	**11. E-mail Address**
12. Signature	**13. Date of Signature** (mm/dd/yyyy)

For TDI-DWC Use Only

Frequently Asked Questions
Employer Notice of No Coverage or Termination of Coverage

Who must file the DWC Form-005?
An employer who **does not have** workers' compensation insurance (non-subscriber) must file the DWC Form-005, unless the employer's only employees are exempt from coverage under the Texas Workers' Compensation Act (for example, certain domestic workers, certain farm and ranch workers).

An employer who **terminates** workers' compensation insurance coverage must file the DWC Form-005.

Failure to file the form when required may subject the employer to administrative penalties.

When do I file the DWC Form-005?
An employer who uses the DWC Form-005 to file a **notice of no coverage** must file:

- annually between February 1st and April 30th of each calendar year;
- within 30 days of the employer hiring its first employee, unless this due date falls between February 1st and April 30th and the employer submits the notice within this time period; and
- within 10 days of receipt of a TDI-DWC request for filing a notice of no coverage.

An employer who uses the DWC Form-005 to file a **notice of termination of coverage** must file:

- within 10 days after notifying the insurance carrier of the termination of coverage unless the employer purchases a new policy or becomes a certified self-insurer; and
- thereafter, the employer must file the DWC Form-005 as a non-subscriber as long as the employer remains in operation and does not have workers' compensation insurance coverage.

How do I file the DWC Form-005?
Employers can submit the DWC Form-005 to the TDI-DWC by:

- filing electronically on the TDI website at: https://txcomp.tdi.state.tx.us/TXCOMPWeb/common/home.jsp;
- faxing the form to (512) 804-4146; or
- mailing the form to the address listed at the top of the form (if the filing is for **termination of coverage,** the submission must be by certified mail).

How/when must a non-subscriber notify employees that workers' compensation coverage is not provided?
An employer **must post** the *Notice to Employees Concerning Workers' Compensation in Texas* in the workplace in English, Spanish and any other language common to the employer's employee population in the print type specified by TDI-DWC rules whenever the employer:

- elects to not have workers' compensation insurance;
- cancels or terminates workers' compensation insurance;
- withdraws from certified self-insurance; or
- has its workers' compensation coverage cancelled by the insurance company.

The employer **must also provide** this notice to each employee:

- at the time of hire;
- when the employer elects to not have workers' compensation insurance;
- within 15 days of notification to the insurance carrier that the employer is terminating coverage unless the employer maintains continuous coverage under a new policy or becomes a certified self-insurer; or
- within 15 days of cancellation by the insurance company.

The required notice may be found on the TDI website at:
http://www.tdi.texas.gov/forms/dwc/notice5.pdf (English) and
http://www.tdi.texas.gov/forms/dwc/notice5s.pdf (Spanish).

Are non-subscribers required to file other forms with the TDI-DWC?
Employers with five or more employees are required to report work-related injuries and diseases to the TDI-DWC. Non-subscribers and covered employers whose employee(s) have waived workers' compensation insurance coverage must report these work-related injuries and diseases using the DWC Form-007, *Employer's Report of Non-covered Employee's Occupational Injury or Diseases*. The form must be filed not later than the 7th day of the month following the month in which:

- a work-related death occurred,
- an employee was absent from work for more than one day* as a result of an on-the-job injury, or
- the employer acquired knowledge of an occupational disease.

*Do not count the day of the injury or the day the injured employee returned to work when calculating the number of days absent from work.

The DWC Form-007 can be obtained from the TDI website at:
http://www.tdi.texas.gov/forms/dwc/dwc7.pdf.

Are any fields on the DWC Form-005 optional?
No, all applicable fields must be completed each time the DWC Form-005 is filed.

Additional information can be obtained from the TDI website at:
http://www.tdi.texas.gov/wc/employer/index.html or by calling 1-800-372-7713**.**

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

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Employer's Report of Non-covered Employee's Occupational Injury or Disease

Type or print in black ink

☐ **Non-subscribing Employer**
☐ **Subscribing Employer - Employee Waived Workers' Compensation Insurance Coverage**

I. EMPLOYER INFORMATION

1. Employer Business Name			
2. Reporting Period (mm/yyyy)	**3. Number of Injured Employees Included on This Report**		
4. Employer Business Mailing Address (Street or PO Box, City, County, State, Zip Code)		**5. Provide the following:**	
		NAICS Codes	**NAICS Employment**
6. Employer Physical Address (Street, City, State, Zip Code)			
7. Employer Phone Number			
8. Federal Employer ID Number			
9. Name of Person Completing Form			
10. Phone Number of Person Completing Form			
11. Title of Person Completing Form			
12. Signature of Person Completing Form		**13. Date of Signature** (mm/dd/yyyy)	

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**
22. Race/Ethnic Identification ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (specify)		

For TDI-DWC Use Only

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)	
24. Type of Location Where Injury/Occupational Disease Occurred ☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations	
25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)
27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)	
28. Reported Cause of Injury	
29. Nature of Injury/Occupational Disease	
30. Equipment Involved in the Injury (if any)	
31. Body Part(s) Affected	
32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)
36. Description of Incident	

NOTE[1]: Title 28 Texas Administrative Code, Chapter 160 requires employers to report work-related deaths, on-the-job injuries and occupational diseases in the form and manner required by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004)

Employer's Name: Employer's FEIN:	For TDI-DWC Use Only

Injury Data for Additional Injured Employee(s)
(reproduce this page, if necessary)

Employer Business Name	
Employer FEIN	**Reporting Period** (mm/yyyy)

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**

22. Race/Ethnic Identification
☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
☐ Other (specify)

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)

24. Type of Location Where Injury/Occupational Disease Occurred
☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations

25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)

27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)

28. Reported Cause of Injury

29. Nature of Injury/Occupational Disease

30. Equipment Involved in the Injury (if any)

31. Body Part(s) Affected

32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)

36. Description of Incident

For TDI-DWC Use Only

Frequently Asked Questions
Employer's Report of Non-covered Employee's Occupational Injury or Disease (DWC Form-007)

Which employers are required to report on-the-job injuries, occupational diseases, and work-related deaths on the DWC Form-007?

The following employers are required to file the DWC Form-007:

- An employer that **does not have** workers' compensation insurance coverage (non-subscriber) and **employs five or more employees who are not exempt** from workers' compensation insurance coverage must file the DWC Form-007 to report all on-the-job injuries and occupational diseases. Examples of exempt employees include certain domestic workers, and certain farm and ranch workers.
- An employer that **has** workers' compensation insurance coverage must file the DWC Form-007 to report an on-the-job injury or occupational disease for an **employee who has waived** workers' compensation insurance coverage in accordance with Texas Labor Code §406.034.

Failure to file the form may subject the employer to administrative penalties.

What do I do if I need to report more than two injured employees?
Copy page three of the form as many times as necessary for reporting additional injured employees.

When do I file the DWC Form-007?
The form must be filed not later than the 7th day of the month following the month in which:

- a work-related death occurred,
- an employee was absent from work for more than one day* as a result of an on-the-job injury; or
- the employer acquired knowledge of an occupational disease.

*Do not count the day of the injury or the day the injured employee returned to work when calculating the number of days absent from work.

NOTE: If no such deaths, injuries, or diseases occurred during a calendar month, no report is required for that month.

Are any fields on the DWC Form-007 optional?
No, all applicable fields must be completed each time the DWC Form-007 is filed.

How do I file the DWC Form-007?
Submit the DWC Form-007 to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by:

- faxing the form to (512) 804-4146; or
- mailing the form to the address listed at the top of the form.

Instructions for Completing Specific Items

Box 5: Employer NAICS Codes*/Employment
List all six-digit NAICS Codes which the employer uses with the FEIN specified in Box 8. Provide the highest employment figure for each NAICS Code for the month of the report. Employment means all employees on your payroll whether full-time, part-time, temporary, or permanent. Attach additional pages, if necessary.

Box 21: Employee NAICS Code*
List the six-digit NAICS Code of the activity that the employee was engaged in at the time of the injury or disease. The code listed must be one of the six-digit NAICS Code numbers reported in Box 5.

Box 22: Race/Ethnic Identification
Check appropriate box and provide requested information, if applicable. Information as to the race/ethnicity of the employee will be maintained for non-discriminatory statistical use.

NOTE: Hispanic, while not a race identification, is included as a separate race/ethnic category. Do not include Hispanic under "white" or "black".

Box 28: Reported Cause of Injury
Enter the most probable cause of the injury or disease. Examples: overexertion due to lifting or pushing, caught between, slip, trip, fall.

Box 29: Nature of Injury/Occupational Disease
Enter the type of injury or occupational disease. Examples: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. For multiple injuries, use most serious.

Box 33: Number of Days Absent from Work

- *Occupational disease*: Must be reported regardless of the number of days the employee is absent from work. Check the appropriate box, including *1 Day or Less*.
- *On-the-job injury*: Must be reported only if the employee is absent from work for more than one day. Do not check *1 Day or Less*.

Box 36: Description of Incident
Provide a short narrative of how the incident occurred. Example: While painting house, fell off ladder and fractured arm.

*Information on NAICS Codes can be found on the United States Census Bureau website at www.census.gov/eos/www/naics. NAICS Codes can also be obtained from the *North American Industry Classification System* published by the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161; e-mail: info@ntis.fedworld.gov.

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Name of employer] _____ does not have workers' compensation insurance coverage. As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered (non-subscribing) employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits for a work-related injury or occupational disease. In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease. 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.

SAFETY VIOLATIONS HOTLINE: The Division has a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers 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 the Division at 1-800-452-9595.

Non-Covered Employer

Texas Workers' Compensation Rule 110.101(e)(4) requires employers who are not covered by workers' compensation, either by election, cancelation or termination of coverage to advise their employees that they do not have workers' compensation insurance coverage.

Notices in English, Spanish and any other language common to the employer's employee population must be posted and:

1. Prominently displayed in the employer's personnel office, if any;
2. Located about the workplace in such a way that each employee is likely to see the notice on a regular basis;
3. Printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type; and
4. Contain the exact words as prescribed in Rule 110.101(e)(4).

The notice on the reverse side meets the above requirements. Failure to post or to provide notice as required in the rule is a violation of the Act and Division rules. The violator may be subject to administrative penalties.

Do Not Post This Side

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YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Quy tắc dẫn chiếu 110.101

(a) Ngoài thông báo được niêm yết theo yêu cầu tại tiểu mục (e) của mục này, các chủ nhân, như được định nghĩa tại Mục 406.001 của Bộ Luật Lao Động, phải thông báo bằng văn bản cho các nhân viên của mình về tình trạng phạm vi bảo hiểm bồi thường lao động. Thông báo bổ sung này:

(1) sẽ được cung cấp vào thời điểm nhân viên được thuê tuyển, có nghĩa là khi nhân viên được pháp luật liên bang yêu cầu phải hoàn tất cả mẫu W-4 và mẫu I-9 hoặc khi đã xảy ra sự gián đoạn trong công việc, và nhân viên được pháp luật liên bang yêu cầu phải hoàn tất mẫu W-4 vào ngày đầu tiên nhân viên trở lại làm việc;

(2) sẽ được cung cấp cho mỗi nhân viên, bởi chủ nhân khi phạm vi bảo hiểm bồi thường lao động bị chấm dứt hoặc huỷ bỏ, không trễ hơn ngày thứ 15 sau ngày phạm vi bảo hiểm bị chấm dứt hoặc huỷ bỏ có hiệu lực;

(3) sẽ được cung cấp cho mỗi nhân viên, bởi chủ nhân nhận được phạm vi bảo hiểm bồi thường lao động, không trễ hơn ngày thứ 15 sau ngày phạm vi bảo hiểm đó có hiệu lực, để cho phép nhân viên lựa chọn tiếp tục các quyền lợi cần thiết theo thông luật theo Chương 406 Đạo Luật Lao Động;

(4) sẽ bao gồm cả phần nội dung được yêu cầu trong thông báo được niêm yết (xem quy tắc 110.101 (e)(1), (e)(2), (e)(3), (e)(4) để sử dụng ngôn ngữ phù hợp); và

(5) nếu chủ nhân có phạm vi bảo hiểm bồi thường lao động (có ghi danh) hoặc được phạm vi bảo hiểm, dù qua bảo hiểm thương mại hoặc qua hình thức tự bảo hiểm như được quy định bởi Đạo Luật Bồi Thường Lao Động Tiểu Bang Texas (Đạo Luật), sẽ bao gồm tuyên bố sau:

THÔNG BÁO GỬI CHO CÁC NHÂN VIÊN MỚI

"Bạn có thể chọn tiếp tục các quyền lợi cần thiết của mình theo thông luật nếu, không quá 5 ngày sau khi bạn được tuyển dụng hoặc trong vòng 5 ngày sau khi nhận được văn bản thông báo của chủ nhân rằng chủ nhân đã có bảo hiểm bồi thường lao động, bạn báo cho chủ nhân của bạn bằng văn bản là bạn muốn tiếp tục các quyền lợi cần thiết của mình theo thông luật để bù đắp cho thiệt hại đối với thương tích cá nhân. Nếu bạn chọn tiếp tục các quyền hành động theo thông luật, bạn không thể nhận được lợi tức hoặc những quyền lợi về y tế từ bồi thường lao động nếu bạn bị thương tích."

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YOU MAY USE YOUR OWN LETTERHEAD WITH THE FOLLOWING INFORMATION

Reference Rule 110.101

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code Section 406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:

(1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;

(2) shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;

(3) shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;

(4) shall include the text required in the posted notice (see rule 110.101 (e)(1), (e)(2), (e)(3), (e)(4) for appropriate language); and

(5) if the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement:

NOTICE TO NEW EMPLOYEES

"You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."