TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
7551 METRO CENTER DRIVE, SUITE 100
AUSTIN, TEXAS 78744

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S REPORT FOR REIMBURSEMENT OF VOLUNTARY PAYMENT (DWC Form-002)

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 XXX-XX-
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 Department of Insurance, Division of Workers' Compensation and the insurance carrier within 7 days after the date of initial payment. An employer who fails to timely file the report of injury or occupational disease as required by Section 409.005, of the Texas Workers' Compensation Act waives the right to reimbursement of any voluntary payments and may be assessed an administrative penalty. 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 Section 409.009, of the Texas Workers' Compensation Act.

The insurance carrier should reimburse the employer within 7 days after receiving the request and should notify the Texas Department of Insurance, Division of Workers' Compensation within 7 days of payment of the amount and date of the reimbursement.