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

Type or print each item on this form in black ink
-OR-
Submit 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 **ELECTS NOT TO OBTAIN** 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:
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 Illnesses
Did you have any reportable employee injuries or illnesses 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, *Non-covered Employer's Report of Occupational Injury or Illness.*
(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 State Zip)	
6. Employer Business Type	**7. Six-Digit NAICS Code**

III. ADDITIONAL BUSINESS LOCATIONS

Provide name, Federal Employer ID number and address of <u>each</u> Texas business location, subsidiary, or separate entity of the primary employer covered by this report. If more space is needed to identify additional locations, submit a DWC Form-205, *Locations of Employer's Business(es)*.

8. Name	**9. Federal Employer ID Number**
10. Address (Street or PO Box, City State Zip)	
11. Name	**12. Federal Employer ID Number**
13. Address (Street or PO Box, City State Zip)	
14. Name	**15. Federal Employer ID Number**
16. Address (Street or PO Box, City State Zip)	
17. Name	**18. Federal Employer ID Number**
19. Address (Street or PO Box, City State Zip)	

IV. PERSON PROVIDING INFORMATION

20. Name	**21. Telephone Number**	For TDI-DWC Use Only
22. Title	**23. E-mail Address**	
24. Signature	**25. Date**	

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).**

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

Who must file the DWCForm-005?
All employers (including former sole proprietors who have formed corporations which have only one employee) must file a DWC Form-005 with the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) **except** an employer who:

- has workers' compensation insurance;
- is a certified self-insurer;
- is a self-insured political subdivision; or
- employs only employees who are exempt from coverage under the Texas Workers' Compensation Act (for example, domestic workers, certain farm and ranch workers).

Where/when do I file the form?
Fax the form to TDI-DWC at (512) 804-4146 or mail it to the address at the top of the form. The following deadlines apply to the filing of the DWC Form-005.

- An employer **who elects not to be covered** by workers' compensation insurance must file the DWC Form-005:
  - within 30 days of hiring an employee who is subject to coverage under the Texas Workers' Compensation Act; or
  - within 30 days (10 days if the employer is **principally located outside Texas)** of receipt of a TDI-DWC request for coverage status, whichever comes first.

- An employer **who cancels workers' compensation insurance** must file within 10 days after notifying the insurance carrier of cancellation unless the employer purchases a new policy or becomes a certified self-insurer.

NOTE: Employers must file the DWC Form-005 **annually on the anniversary date of the original filing** as long as they remain in operation and do not carry workers' compensation insurance.

How/when must a non-covered employer 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 not to be covered by 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 hiring;
- when the employer elects not to be covered by workers' compensation insurance;
- within 15 days of notification to the insurance carrier that the employer is dropping 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 is attached and may also be found at:
http://www.tdi.state.tx.us/forms/dwc/notice5.pdf (English) and http://www.tdi.state.tx.us/forms/dwc/notice5s.pdf (Spanish).

If an employer chooses to cancel workers' compensation insurance, when does coverage end?
The insurance carrier must extend coverage for 30 days after the employer files notice with TDI-DWC or until the date of cancellation, whichever is later. Premiums are due until such date.

Are non-covered employers required to file other forms with TDI-DWC?
Employers with 5 or more employees are required to report work-related injuries and illnesses to TDI-DWC. Employers must report each work-related injury or illness by the seventh day of the following month. Non-covered employers should report these injuries and illnesses using the DWC Form-007, *Non-covered Employer's Report of Occupational Injury or Illness*, for each:

- work-related injury resulting in the employee's absence from work for more than one day;
- occupational disease of which the employer has knowledge; and
- work-related fatality.

The DWC Form-007 can be obtained at http://www.tdi.state.tx.us/forms/dwc/dwc7.pdf.

WARNING: The following may subject a non-covered employer to administrative penalties:

- failure to file a DWC Form-005
- failure to post or provide required notices and/or
- withholding information or providing fraudulent or inaccurate information

Additional information can be found at http://www.tdi.state.tx.us/wc/employer/filings.html#faq or by calling 1-800-372-7713**.**

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: [Employer Name] has elected not to obtain 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 employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. 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 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. 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 Workers' Health and Safety at 1-800-452-9595.

AVISO A EMPLEADOS SOBRE COMPENSACIÓN PARA TRABAJADORES EN TEXAS

COBERTURA: [Nombre del Empleador] ha elegido no obtener cobertura de seguro de compensación para trabajadores. Como empleado de un empleador que ha elegido no tener seguro de compensación; usted no puede recibir beneficios de compensación dentro de la Ley de Compensación para Trabajadores de Texas. Sin embargo, un empleador puede y debe proporcionar otros beneficios a los empleados lesionados. Usted debe comunicarse con su empleador para obtener información sobre la disponibilidad de otros beneficios o compensación por una lesión o enfermedad relacionada con el trabajo. Además, usted puede tener derechos bajo la ley de "Derecho Común de Texas", en caso de que usted sufriese una lesión o enfermedad relacionada con su trabajo. Su empleador debe proporcionarle información sobre la cobertura, por escrito, cuando usted es contratado o cuando su empleador adquiere o deje de tener cobertura de seguro de compensación para trabajadores.

LÍNEA TELEFÓNICA 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 a cualquier empleado porque el o ella, de buena fe, reporta una supuesta violación ocupacional de salud o seguridad. Comuníquese con la Sección de Seguridad y Salud al número 1-800-452-9595.