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

DWC Use Only (Microfilm#)

INSURANCE CARRIER NOTICE OF COVERAGE/CANCELLATION/NON-RENEWAL OF COVERAGE

Insurance Carrier Information

1. Insurance Carrier Name

2. Federal Tax ID No/ (FEIN)

3. NCCI No.

4. DWC Carrier (MBI No.)

5. Policy Type

☐ Standard ☐ Divided Risk

Type of Transaction (check one only)

☐ New Policy

☐ Carrier 10 days Cancellation/Non Renewal

☐ Carrier 30 days Cancellation/Non Renewal

☐ Correction/Revision/Endorsement (attach DWC FORM-20A)

☐ Renewal ☐ Reinstatement

☐ Voluntary Backdated Effective Date of Policy

Employer/Insured Information

7. Primary Employer/Insured Name

8. Primary Employer/insured Business Mailing Address

9. No. of Locations and/or entities covered. (Exclude Primary Insured)

10. Federal Tax ID No.

11. Employer's Workers' Comp Class Code

12. Estimated No. of Employees

POLICY INFORMATION

13. Policy No.

14. Effective Date of Policy: (mm-dd-yy)

From To

15. Effective Date of Cancellation/Reinstatement: (mm-dd-yy)

16. Date Carrier Notified Employer of Cancellation

17. Employer/insured DBA Name

DIVIDED RISK INFORMATION

18. Job site policy project or other specific operation name which this policy covers and site location/address
Check one:

☐ ADD ▷ Effective Date

☐ DELETE

Name

Address

Federal Tax ID Number

Number of Employees

City Sate Zip

For additional locations ** use DWC FORM-205 **

19. Signature of Insurance Carrier Representative

20. Date of Notice