TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

CLAIM # _____

Carrier's Claim # _____

EMPLOYER'S CONTEST OF COMPENSABILITY

1. Employee's Name (Last, First, M.I.)	4. Employer's Name (Last, First, M.I.)	
	5. Employer's Mailing Address (Street or P.O. Box)	
2. Social Security Number - -	City State Zip Code	
3. Date of Injury - -	6. Employer's Telephone No. ( )	7. Insurance Carrier

In accordance with Art. 8308-5.10 of the Texas Workers' Compensation Act, the employer has the right to contest the compensability of an employee's injury if the insurance carrier accepts liability for the payment of benefits.

8. Provide any relevant facts supporting the reason(s) for contesting compensability.

Division Date Stamp Here

Employer's Signature _____ Date _____

Title _____

DWC FORM - 4
(Employer's Contest of Compensability)

An **employer** desiring to contest the compensability of a claim that the insurance carrier has accepted may file an **Employer's Contest of Compensability** with the Texas Department of Insurance, Division of Workers' Compensation (DWC).

The employer may contest compensability of a claim after presenting the grounds for non-compensability to the carrier and giving the carrier the opportunity to contest compensability. The employer may file the FORM-4 no later than 50 days after the date the insurer received written notice of the injury.

This will be printed as a single page form. The form is considered filed when personally delivered or postmarked. Send to the **DWC field office handling the claim**.

[Art. 8308, Sec. 5.10. Employer Bill of Rights, Texas Workers' Compensation Act]