

CLAIM # _____
 Carrier's Claim # _____

EMPLOYEE'S REQUEST FOR ACCELERATION OF IMPAIRMENT INCOME BENEFITS

1. Employee's Name	4. Employee's Telephone Number
2. Mailing Address (Street or P.O. Box)	5. Date of Injury
City State Zip Code	6. Insurance Company's Name
3. Employee's Social Security Number	7. Employer's Name
8. Amount of Acceleration Requested (The accelerated payment cannot exceed your weekly net pre-injury wage which is based on 85% of your average weekly wage before your injury.) \$ _____	
9. Please explain the reasons for your hardship that is the basis for requesting acceleration of your impairment income benefits.	

INJURED EMPLOYEE: PLEASE READ CAREFULLY

10. a) This form is to be completed and filed with the Texas Department of Insurance, Division of Workers' Compensation only if you are receiving weekly impairment income benefits **and** if there is not a pending dispute of the impairment rating.

b) Acceleration of impairment income benefits will increase the amount of your weekly checks but will reduce the number of weeks you will receive impairment income benefits.

c) If you are entitled to supplemental income benefits and you receive accelerated payment of impairment income benefits, the payment period for supplemental income benefits will not begin until after the end of the original number of weekly impairment income benefits. This means that you will not receive any weekly benefits between your last accelerated payment of impairment income benefits and the beginning of supplemental income benefits.

I have read the above and understand how acceleration will affect my weekly payments. I certify that the information I have provided is correct to the best of my knowledge.

Signature of Injured Employee _____ Date _____

DIVISION ORDER

Acceleration Approved The insurance company shall initiate accelerated payments no later than 7 days after receiving notice of the Division's approval. (See reverse side for calculation of payments.)

Number of accelerated payments _____ Amount of accelerated payments \$ _____

Acceleration Denied Reason for denial: _____

Authorized DWC Employee's Signature _____

Title _____ Telephone Number _____ Date _____



Calculation of Accelerated Payments

Date Worksheet Completed: _____ Interest Rate Used: _____

Impairment Income Benefits (IIBs) Period: From _____ To _____

1. Calculate weekly IIBs rate.

$$\frac{\$ \text{_____}}{\text{Average Weekly Wage}} \times 70\% = \$ \frac{\text{_____}}{\text{Weekly IIBs Rate}}$$

2. Calculate weekly net pre-injury wage.

$$\frac{\$ \text{_____}}{\text{Average Weekly Wage}} \times 85\% = \$ \frac{\text{_____}}{\text{Weekly Net Pre-injury Wage}}$$

The weekly accelerated payment cannot exceed this amount.)

3. Determine number of weeks remaining due in the IIBs period and discount.*

*Instructions to Authorized DWC staff: Using the "Present Value of Future Weekly Payments Discounted at a Given Discount Rate" chart in effect at the time acceleration is requested, locate the number of weeks of remaining IIBs. The number in the box to the right of the number of remaining weeks is the discounted value of those weeks.

Remaining number of weeks _____ Discounted number/value of weeks _____

4. Calculate discounted IIBs amount due.

$$\frac{\text{_____}}{\text{Number Discounted Weeks}} \times \$ \frac{\text{_____}}{\text{IIBs Weekly Rate}} = \$ \frac{\text{_____}}{\text{Total Discounted Amount}}$$

5. Calculate acceleration payment period.

$$\frac{\$ \text{_____}}{\text{Total Discounted Amount}} \div \frac{\$ \text{_____}}{\text{Weekly Net Pre-injury Wage (or requested amount)}} = \frac{\text{_____}}{\text{Number Weeks Accelerated IIBs}}$$

6. Calculate number of weeks and weekly amount.

_____ Weeks @ \$ _____ and if necessary, Partial Week _____ @ \$ _____

