Send to:
Injured Employee
DWC Field Office Handling Claim

CLAIM # _____

CARRIER'S CLAIM # _____

REQUEST TO ADJUST AVERAGE WEEKLY WAGE FOR SEASONAL EMPLOYEE

Instructions for Insurance Carrier: The insurance carrier's records show that the employee in the claim shown below has failed to furnish the wage information requested on _____. _____ now requests the
DATE CARRIER

Division's approval to adjust the injured seasonal employee's average weekly wage from $_____ to $_____ beginning _____ and ending on _____. Attach _____
DATE DATE TYPE OF EVIDENCE
showing the employee's earnings during the same period in previous years.

A copy of this request must be provided to the injured worker at the same time it is submitted to the Division's field office handling the claim. Date mailed to Division and Employee: _____

1. Employee's Name (Last, First M.I.) **and** Telephone Number ( )	2. Social Security Number	3. Date of Injury
4. Mailing Address (Street or P.O. Box)	5. Employer's Business Name	
City State ZIP Code	6. Insurance Carrier's Name	

• • • NOTICE TO EMPLOYEE • • •

A representative of the Division will attempt to contact you upon the Division's receipt of the insurance carrier's Request to Adjust Average Weekly Wage for Seasonal Employee to explain the purpose of this request and to determine whether you agree with the request to adjust your average weekly wage and your weekly temporary income benefit payment. **Within the next 2 weeks you may request a Benefit Review Conference if you do not agree with the request for adjustment. Your dispute will be set for a Benefit Review Conference within 20 days of your request. You can give additional wage information for consideration. However, if you do not request a Benefit Review Conference within this period, the Division will approve the request for adjustment based on the wage information available.**

If you have any questions or need help, call the Texas Department of Insurance, Division of Workers' Compensation at 1-800-252-7031 or contact the Division field office handling your claim.

FOR DIVISION USE

The insurance carrier's Request to Adjust Average Weekly Wage for Seasonal Employee in the above styled claim is:

☐ **APPROVED.** Employee failed to request a Benefit Review Conference within the required 2-week period set forth above.

The average weekly wage is adjusted to $_____, and the temporary income benefit weekly payment is adjusted to $_____, beginning _____ and ending _____.

☐ **NOT APPROVED.** Reason: _____

DWC Disability Determination Officer (SIGNATURE)	Division Field Office Phone Number ( )
Division Field Office Address	City State ZIP Code