CARRIER REPRESENTATIVE INFORMATION SUBMISSION FORM

Name of Carrier/Self-Insured ______________________ FEIN# __________

Group Affiliation ______________________

Effective Date ______________________

Insurance Carrier's E-mail Addresses

Claims ______________________

Underwriting ______________________

CARRIER PRIMARY MAILING ADDRESS FOR CORRESPONDENCE FROM THE DIVISION

Mailing Address ______________________

____

City/State/ZIP ______________________

AUSTIN REPRESENTATIVE
(i.e., Name of Carrier Representative before the Division in Austin):

Company Name ______________________ FEIN# __________

Mailing Address ______________________

____

City/State/ZIP ______________________

E-Mail Address ______________________

Telephone Number ______________________ Fax Number ______________________

Signature ______________________ Date ______________________

Title ______________________

This form may be reproduced.

Please return this form to:

Texas Department of Insurance,
Division of Workers' Compensation
Insurance Coverage Section; MS-96
7551 Metro Center Drive, Suite 100
Austin, TX 78744

or fax to (512) 804-4346

DWC USE ONLY	
Changes made by	
Participant ID#	
DWC Box #	
Date