Send to:
TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
Field Office Handling Claim

CLAIM #_____

Carrier's Claim #_____

EMPLOYEE'S REQUEST FOR PAYMENT OF ADVANCE COMPENSATION

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 Advance Requested $_____

9. Please explain the reasons for the hardship that is the grounds for requesting an advance of your income benefits.

INJURED EMPLOYEE: PLEASE READ CAREFULLY

10. a) No more than three advances can be granted based on the same injury.
    b) The advance cannot exceed four times the maximum weekly temporary income benefit in effect on your date of injury. If you have questions about this limit, please call 1(800)252-7031.
    c) An advance will reduce the amount of future weekly income benefits. This reduction will be determined in accordance with the amount advanced and the number of weeks that benefits are likely to be paid in the future. Weekly payments may be paid in this reduced amount until the insurance company recovers the amount advanced.

Amount currently receiving weekly $_____ Maximum Weekly reduction to pay back advance $_____

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

Signature of Injured Employee _____ Date _____

DIVISION ORDER

☐ Advance Approved The insurance company shall initiate advanced payments within 7 days of receipt of notice from the Division by the insurance company's Austin representative. Amount of advance $_____

Reduce income benefit amount $_____ for _____ weeks; and partially reduce the income benefit amount $_____ for the _____ week.

This reduction shall be in addition to any previous orders for reductions.

☐ Advance Denied Reason for denial: _____

_____

Authorized DWC Employee's Signature _____

Title _____ Telephone Number _____ Date _____

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that DWC collects on its forms about you. For more information, call our Open Records section at 512-804-4437.