NOTIFICATION OF FIRST TEMPORARY INCOME BENEFIT PAYMENT

DATE:

TO: [NAME OF INJURED EMPLOYEE]
[ADDRESS]
[CITY, STATE, ZIP]

RE: [DATE OF INJURY]
[NATURE OF INJURY]
[PART OF BODY INJURED]
[EMPLOYEE SSN]
[CLAIM #]
[CARRIER NAME/TPA NAME]
[CARRIER CLAIM#]
[EMPLOYER NAME]
[EMPLOYER ADDRESS]
[EMPLOYER CITY, STATE, ZIP

Your first payment of workers' compensation benefits for the period of (***first day of period being paid***) to (***last day of period being paid***) is being issued. The benefit payment is called "Temporary Income Benefits" (**TIBs**) and is paid weekly. Entitlement to TIBs begin after you have had lost wages for more than 7 days. TIBs began on (***date of eighth day of disability***) which was your eighth day of disability. The TIBs weekly benefit amount of (***$$$***) is based on the reported Average Weekly Wage of (***$$$***).

Please inform us within **3 days** if you:

- Start earning income from the same employer, a different employer, or from self-employment; or
- Have any change in earnings resulting from your injury, either an increase or decrease; or
- Have an offer of employment at any wage level.

You are encouraged to contact your employer regarding any return to work program that will allow you to work within the restrictions prescribed by your treating doctor.

If you are expected to be paid benefits for a period of eight weeks or more, you may request that we make your benefit payments by electronic funds transfer directly to your bank account. Also, you may request that we change your TIBs from a weekly payment to a monthly payment.

Explanatory Comments: (free text for explanatory comments)_____
_____

If you do not agree with the amount of weekly income benefits being paid, please contact me:

Adjuster's Name: _____
Toll Free Telephone #: _____
Fax #/E-mail Address: _____

If we are unable to resolve the issue to your satisfaction, you may contact the Texas Department of Insurance, Division of Workers' Compensation for further assistance. You have the right to request a Benefit Review Conference. You can contact the Division office handling your claim at 1-800-252-7031.

If you would like to receive notices such as this by facsimile or e-mail, please contact me and provide your facsimile number or e-mail address.

Please note that making a false or fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.

Cc:

INSTRUCTIONS:

Notification of First Payment (DWC FORM PLN-2), Rule 124.2 (e)(1) and (f): (MTC: IP)

This is the Notification of First Payment letter for benefit type 050 (**TIBs**). This notice should only be used to report to the injured employee/representative the initial payment of TIBs indemnity benefits on a claim.

1. Provide this letter to the employee upon the initiation of temporary income benefits.
2. Include the start and end dates for the period being paid.
3. Include the date income benefits began to accrue (8th day of disability).
4. Include the TIBs rate.
5. Include the Average Weekly Wage that payment of income benefits is based on.

DO NOT SEND THIS LETTER TO THE TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION