Texas Department Of Insurance
Division of Workers' Compensation
Insurance Coverage Section
7551 Metro Center Dr. Ste.100 • MS-96
Austin, TX 78744-1609
(512) 804-4000 (512) 804-4346 fax www.tdi.state.tx.us

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 or** ☐ **EBILLING CONTACT**
(i.e., Name of Carrier Representative before the Division in Austin):
Company/Contact Name ______________________ FEIN# ____________

Mailing Address ______________________

____

City/State/ZIP ______________________

E-Mail Address ______________________

Telephone Number ______________________ Fax Number ______________________

Signature ______________________ Date ______________________

Title ______________________ Web Address ______________________

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

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Changes made by	
Participant ID#	
DWC Box #	
Date	