BRAZOS COUNTY
HUMAN RESOURCES DEPARTMENT
200 S. TEXAS AVE SUITE 206, BRYAN,TX 77803
PHONE (979) 361-4181 FAX (979) 823-6993

Workers' Compensation Injury Checklist for Supervisors

Below is an abbreviated checklist which summarizes the county responsibilities when reporting an injury and ensures compliance with the Texas Labor Code.

When an Injury Occurs...

☐ Have the employee fill out the **Employee Report of Injury Form**. Discuss with the employee, if necessary, the facts of the accident.

☐ Supervisor completes the **Employer's First Report of Injury (DWC-1) form**. Do not ask the injured worker to complete this form. The DWC-1 is an employer-required form.

☐ Supervisor submits the completed **Employer's First Report of Injury (DWC-1) form** and the **Employee Report of Injury Form** to Human Resources via email HR@brazoscountytx.gov or fax 979-823-6993.

Items for the Injured Worker

☐ Human Resources will send a copy of the **DWC-1** and the following documents to the injured worker:

- ☐ **MyMatrixx Flyer** (serves as a temporary prescription card)
- ☐ **Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System**

Communication with the Medical Provider

☐ Ensure the provider is aware the accident is/was work-related. **The TAC RMP Notification of WC Coverage Provider** can be used for this purpose.

Questions concerning this document or injury reporting? Contact Human Resources at (979) 361-4181.

Workers' Compensation Injury and Claim Reporting Process
Brazos County

Work- related injury occurs and employee reports to a Supervisor

Supervisor must report any work-related injury or death to Human Resources immediately.

HR must file DWC-1 (First Report of Injury) with TAC RMP and the injured worker within 8 calendar days per Texas Labor Code §409.005.

If necessary, Supervisor must send injured worker to emergency facility or an Alliance Doctor. List available at www.pswca.org.

Law enforcement, EMS and Correctional Officer exposure to a Communicable Disease must be tested within 10 days.

Lost time beyond 7 days?

Yes

Wages must be reported to determine correct income benefit rate. The DWC-3 (Employers' Wage Statement) must be filed with TAC RMP and injured worker per Texas Labor Code §408.063.

County must pay full salary for Law Enforcement Officers.

No

Supervisor must report return to work date to HR. The DWC-6 (Supplemental Report of Injury) must be filed with TAC RMP and the injured worker within 3 days per Texas Labor Code §409.005.

Additional Lost Time?

Yes

Supervisor must report additional lost time to HR. The DWC-6 (Supplemental Report of Injury) must be filed with TAC RMP and the injured worker within 3 days of additional time off work per Texas Labor Code §409.005.

(512) 478-8753 • (800) 456-5974 • (512) 615-8942 FAX • www.county.org • 1210 San Antonio, Austin, TX 78701 • P.O. Box 2131, Austin, TX 78768-2131
Gene Terry, *Executive Director*

Workers' Compensation Injury and Claim Reporting Details

An injured worker must report an on the job injury to a supervisor or someone acting in a supervisory capacity within 30 days of the injury or within 30 days of the date the injured worker knew or should have known about an occupational illness.[1]

When an injury is reported, the employer is required to report it to the TAC (York Risk Services) on the **DWC-1, First Report of Injury** form within 8 calendar days[2]. Failure to file this form timely or properly can result in an Administrative Violation for the county in the event of an audit or complaint.

Depending on the severity of the injury, the supervisor should assist the injured worker with medical treatment. The injured worker may treat with a doctor or his or her choosing or must treat with an Alliance doctor if the county makes the Alliance mandatory for its employees. The provider list is located at www.pswca.org. Please ensure that the injured worker notifies his or her medical provider of the work-related incident to avoid medical bill filing with a healthcare insurance company.

Communicable Diseases and Required Testing

If the injured worker is a law enforcement officer, EMS employee, paramedic, fire fighter or correctional officer, and is exposed to any of the following communicable diseases, he or she is required to be tested for the following communicable diseases[3] within 10 days of the exposure.

"Acquired immune deficiency syndrome (AIDS); amebiasis; anthrax; botulism--adult and infant; brucellosis; campylobacteriosis; chancroid; chickenpox; Chlamydia trachomatis infection; cholera; cryptosporidiosis; dengue; diphtheria; ehrlichiosis; encephalitis; Escherichia coli 0157:H7; gonorrhea; Hansen's disease (leprosy); Heamophilus influenzae type b infection, invasive; hantavirus infection; hemolytic uremic syndrome (HUS); hepatitis, acute viral; human immunodeficiency virus (HIV) infection; legionellosis; listeriosis; Lyme disease; malaria; measles (Rubeola); meningitis; meningococcal infection, invasive; mumps; pertussis; plague; poliomyelitis, acute paralytic; rabies in man; relapsing fever; Rocky Mountain spotted fever; rubella (including congenital); salmonellosis, including typhoid fever; shigellosis; streptococcal disease, invasive Group A; syphilis; tetanus; trichinosis; tuberculosis; tuberculosis infection in persons less than 15 years of age; typhus; Vibrio infection; viral hemorrhagic fevers; and yellow fever."

This list of diseases may change from time to time. To determine the most current list of reportable diseases and exposure criteria refer to Texas Department of Health rules, 25 TAC Chapter 97, Communicable Diseases.

Full Salary for Law Enforcement Officers

According to Texas Constitution Article 3 Section 52e, an opinion by the Texas Attorney General regarding detention officers, an appellate court's opinion regarding a specific case as presented by detention officers, and a Supreme Court opinion, counties are obligated to continue full salary for an injured law enforcement official.

Employee Resignation or Termination

The county is also required to report when an employee is terminated or resigns. The county has 10 days after the termination or resignation date to file a **DWC-6: Supplemental Report of Injury** with the TAC RMP Third Party Administrator, York Risk Services Group and the injured worker[4].

For more information concerning workers' compensation required claim reporting, contact _____.

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[1] Texas Labor Code §409.001

[2] Texas Labor Code §409.005

[3] Division of Workers' Compensation Rule §122.3

[4] DWC Rule §120.3

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____
Last First MI Maiden

Address: _____

City: _____ State: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Email address: _____

Social Security: _____ Gender: M / F

Date of Injury: _____

Employer: _____

Job Title: _____

Work Schedule: _____

1) What was the exact location of the accident (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date _____ Time _____

Name: _____ Title _____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name _____ Phone: _____

Name _____ Phone: _____ Name: _____ Phone: _____

7) Please identify your Primary Care Physician or family doctor: Name: _____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

9) Has a doctor taken you off work? ___Yes ___ No If so, when was the first day you missed work ? _____

10) If the doctor took you off work, have you returned to work? ___Yes ___No If not, when do you think you will return to work? _____

11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ___Yes ___No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature: _____ Date: _____

INSTRUCTIONS FOR EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC FORM-001)

Type (or print in black ink) each item on this form. Failure to complete each item may delay the processing of the injury claim.

Section 409.005, Texas Workers' Compensation Act, requires an Employer's First Report of Injury or Illness (DWC FORM-001 Rev. 10/05 to be filed with the Workers' Compensation Insurance Carrier not later than the eighth day after the receipt of notice of occupational disease, or the employee's first day of absence from work due to injury or death. A copy of this report must be sent to the employee or the employee's representative. For purposes of this section, a report is filed when personally delivered, or postmarked. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.**

If a report has not been received by the carrier, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause existed if the employer failed to file the report on time.

An employer who fails to file the report without good cause may be assessed an administrative penalty. An employer who fails to file the report without good cause waives the right to reimbursement of voluntary benefits even if no administrative penalty is assessed.

Once the employer has completed all information pertaining to the injury the employer should maintain the copy of this report to serve as the Employer's Record of Injury required by Section 409.006. Send the specified copies to your **Workers' Compensation Insurance Carrier** and the injured employee. ***Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, unless the Division specifically requests a direct filing.** The Division's Health and Safety will use data from this report for the Job Safety Information System established in Section 411.032 of the Texas Workers' Compensation Act.

This report may not be considered admission or evidence against the employer or the insurance carrier in any proceeding before the Division or a court in which facts set out in the report are contradicted by the employer or insurance carrier.

"SPECIAL INSTRUCTIONS FOR CERTAIN ITEMS"

Items 2,7,8:	Section 402.082, Texas Workers' Compensation Act requires the Division to maintain information as to the race, ethnicity and sex on every compensable injury. This information will be maintained for non-discriminatory statistical use.
Item 4:	If no home phone, please provide a phone number where the employee can be reached.
Items 5,15,17, 26,29,30:	Enter data in month, day, year format. Example: 08-13-54.
Item 18:	List nature of accident or exposure, e.g., fall from scaffold, contact with radiation, etc. If occupational disease, so state.
Item 19:	List specific body part, e.g., chin, right leg, forehead, left upper arm, etc. If more than one body part is affected, list each part.
Item 20:	Describe in detail (1) the events leading up to the injury/illness, (2) the actual injury, e.g., cut left forearm, broken right foot, etc., and (3) the reason(s) why accident/injury occurred. Use an additional sheet of paper if necessary.
Item 22:	State the exact work-site location of the injury, e.g., construction site, office area, storage area, etc.
Item 24:	List object, substance, or exposure that directly inflicted the injury or illness, e.g., floor, hammer, chemicals, etc.
Items 32,33:	Enter date in month-year format. Example: 02-56.
Item 37:	Enter the number of days or hours that make up a full work week for your employees.
Item 45:	Enter the 6-digit North American Industry Classification System (NAICS) Code of the employer. The primary code is the code which appears in block 5 of Form C-3, "Employer's Quarterly Report" to the Texas Workforce Commission.
Item 46:	For companies with a single NAICS code, the specific code is the same as the primary code. For companies with multiple NAICS codes, enter the code that identifies the specific business, activity, or work-site location the employee was working in at the time of the injury. This may or may not be the same as the primary code.

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee.

*Employers - Do not send this form to the
Texas Department of Insurance, Division of Workers' Compensation,
Unless the Division specifically requests a direct filling.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☐ M ☐

3. Social Security Number - -	4. Home Phone ( )	5. Date of Birth (m-d-y) - -

6. Does the Employee Speak English? If No, Specify Language
YES ☐ NO ☐

7. Race White ☐ Black ☐ Asian ☐	8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children	12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) - -	16. Time of Injury : am ☐ pm ☐	17. Date Lost Time Began (m-d-y) - -

18. Nature of Injury*	19. Part of Body Injured or Exposed*

20. How and Why Injury/Illness Occurred*

21. Was employee doing his regular job? YES ☐ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site

Street or P.O. Box County

City State Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*

25. List Witnesses

26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES ☐ NO ☐	28. Supervisor's Name	29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES ☐ NO ☐	32. Length of Service in Current Position Months _____ Years _____	33. Length of Service in Occupation Months _____ Years _____

34. Employee Payroll Classification Code	35. Occupation of Injured Worker

36. Rate of Pay at this Job $_____Hourly $_____Weekly	37. Full Work Week is: _____ Hours _____ Days	38. Last Paycheck was: $_____ for ___ Hours or _____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form	41. Name of Business

42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ( )	43. Business Location (If different from mailing address) Number and Street
City State Zip Code	City State Zip Code

44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
74-6000433			

48. Workers' Compensation Insurance Company	49. Policy Number
Texas Association of Counties Risk Management Pool	

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☒ If yes, did you receive them? YES ☐ NO ☒

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date _____

Workers' Compensation Medical Provider Notice

To whom it may concern:

Brazos County is covered by The **Texas Association of Counties Risk Management Pool** for compensable workers' compensation injuries. The Pool contracts with **Sedgwick** to adjust its claims. All medical bills, reports and other supporting documentation may be submitted to the following address for consideration:

TAC Risk Management Pool
P.O. Box 160120
Austin, TX 78716

800.752.6301
512.346-9321 (fax)

US-YORK-tacdwcforms@sedgwick.com

Please note, all bills are subject to retrospective review, reconsideration, and preauthorization under the Texas Workers' Compensation Act.

With the exception of emergency treatment, if the county participates in the Political Subdivision Workers' Compensation Alliance (Alliance), the treating doctor must be chosen from a list of Alliance doctors located at www.pswca.org. Please contact your adjuster at the number above for additional information.

Occupational Injury Temporary Prescription ID Card

myMatrixx
An Express Scripts Company

To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed processing your approved work-related injury prescriptions (based on the guidelines established by your employer).

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx Patient Care Contact Center at 800.945.5951.

Atencion Trabajador Lesionado:

En su Primera visita, porfavor usar este documento en cualquiera de la farmacias listadas, al reverso de este documento. Esto acelerara el procesamiento de sus recetas relacionadas con su caso aprobado de lesion en el trabajo.

¿Tiene preguntas o necesita ayuda para localizar una farmacia de la red participante? Llame al Centro de contacto de atención al paciente myMatrixx al numero 800.945.5951.

sedgwick

Name: _____

ID#: **Present at Pharmacy

Date of Injury: _____

Group #: GJC7937

Employee Date of Birth: _____

WARN ME: OPIOIDS

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

To the Pharmacist:

myMatrixx administers this occupational injury prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 14-day supply or a cost of $1500. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx at 888.786.9640.

Pharmacy Processing Steps

Step 1: Enter bin number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

To the Supervisor:

Please fill in the information requested for the injured worker.

Employee Information

_____ _____ _____
First M Last

_____
Street Address or PO Box

_____ _____ _____
City State ZIP

Employer Name

_____

Participating Retail Network Pharmacies

myMatrixx®
An Express Scripts Company

A & P	Drug Emporium	Longs Drug Store	Schnucks
Acme Pharmacy	Drug Fair	Major Value	Scolari's
Albertson's	Drug Town	Marsh Drugs	Sedano
Albertson's/Acme	Drug World	Medic Discount	Shaw's
Albertson's/Osco	Eckerd	Medicap	Shop 'N Save
Albertson's/Sav-On	Econofoods	Medistat	Shopko
Amerisource Bergen	EPIC Pharmacy	Meijer	ShopRite
Anchor Pharmacies	Network	Minyard	Snyder
Arrow	FamilyMeds	NCS HealthCare	Stop & Shop
Aurora	Farm Fresh	Neighborcare	Sun Mart
Bartell Drugs	Farmer Jack	Network Pharmaceuticals	Super Fresh
Bigg's	Food City	Northeast Pharmacy Services	Super Rx
Bi-Lo	Food Lion	Osco	Target
Bi-Mart	Fred's	P & C Food Markets	Texas Oncology Srvs
BJ's Wholesale Club	Gemmel	Pamida	The Pharm
Brooks	Giant	Park Nicollet	Thrifty White
Brookshire Brothers	Giant Eagle	Pathmark	Times
Brookshire Grocery	Giant Foods	Pavilions	Tom Thumb
Bruno	Hannaford	Price Chopper	Tops
Carrs	Harris Teeter	Publix	Ukrop's
Cash Wise	H-E-B	Quality Markets	United Drugs
Coborn's	Hi-School Pharmacy	Raley's	United Supermarkets
Costco	Hy-Vee	Randalls	Vons
Cub	Jewel/Osco	Rite Aid	Waldbaums
CVS	Kash n Karry	Rosauers	Walgreens
D&W	Keltsch	Rx Express	Wal-Mart
Dahl's	Kerr	RXD	Wegmans
Dierbergs	Kmart	Safeway	Weis
Discount Drugmart	Knight Drugs	Sam's Club	Winn Dixie
Doc's Drugs	Kroger	Sav-On	
Dominicks	LeaderNet (PSAO)	Save Mart	

OFFICE OF INJURED EMPLOYEE COUNSEL

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (1-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800-252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.gov.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**
   If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially choose any doctor who is willing to treat your workers' compensation injury; however,

changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. **If you do not follow these rules, you may be held responsible for payment of medical bills.** OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**