

DWC FORM 3 THROUGH YCE LOGIN

If you only need to submit a DWC-3 form, you will need to login to YCE directly and not go through the claim opening wizard (iCOW). The following instructions will get you to the same DWC-3 module. Save this link in your favorites!!!


<https://www.iclaimsexpert.com/>



You will click to login and then go to your main page. The Login and Password are the same that you will use for submitting a new claim. You will need to enter JIC as the Company name

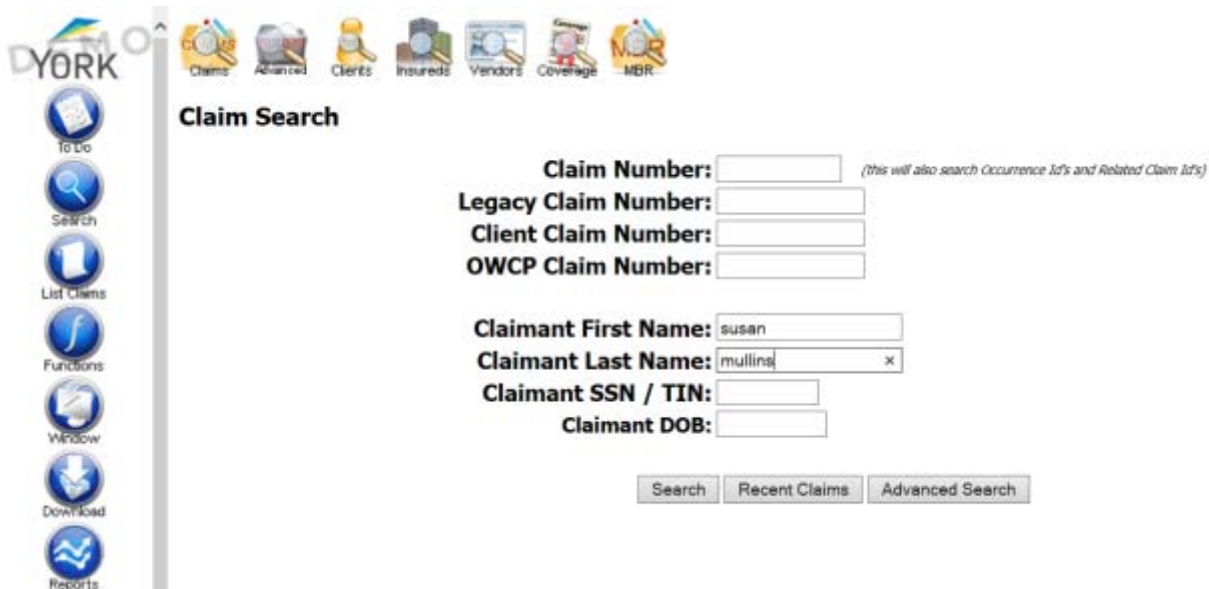


Once you are in the system, you will need to locate the claim you want to submit the DWC-3 on so you will need to

“search” for that claim. This function is on the left side of the screen under the  icon. Select it to search for your claim:



You have several ways you can search, claim number, legacy claim number, name or SSN. I used name:



Claim Search

Claim Number: (this will also search Occurrence Id's and Related Claim Id's)

Legacy Claim Number:

Client Claim Number:

OWCP Claim Number:

Claimant First Name:

Claimant Last Name:

Claimant SSN / TIN:

Claimant DOB:

Hit the search button. All claims with that name will be retrieved. For more common names, please make sure you select the right date of injury. You can narrow it down if you use the claim number if you have it available but many times the name is the fastest way. Once you identify the claim you want to work in, select it by moving your cursor to the claim number [unscored in blue](#).

Claim Search (15 Claims Found) [\[Retain Results List in New Window\]](#)
 + Show Totals

Claim	Claimant Name	LOB	Insured Name	Insured Location (1st)	Carrier	Accident	Status	Adjuster Name	Assigned
5584927	Susan Mullins	TX WC Ind	Demo Insured A	424- Columbus	SIR	06/12/2015	Open	David M Richard	06/23/2015
Description: Picking up a patient to a bed									
5585971	Susan Mullins	IL WC RPO	Demo Insured A	424- Columbus	SIR	06/24/2015	Closed	David M Richard	06/25/2015
Description: Teacher dropped beaker in class. Cut finger on broken glass.									
5586441	Susan Mullins	IL WC RPO	Demo Insured A	424- Columbus	SIR	06/26/2015	Closed	David M Richard	06/26/2015
Description: Teacher burned finger on chemicals.									
5670523	Susan Mullins	TX WC Ind	Demo Insured A	424- Columbus	SIR	08/01/2015	Open	David M Richard	08/13/2015
Description: Lifting boxes									
5670591	Susan Mullins	TX WC Ind	Demo Insured A	424- Columbus	SIR	08/02/2015	Open	David M Richard	08/13/2015
Description: Lifting boxes									

Show Legend Cancel

DWC FORM 3

Forms and Letters

Name	LOB	State
DWC-3 - Employer's Wage Statement	All LOB Codes	Texas
+ Texas DWC-3		
DWC-3 School Districts - Employer's Wage Statement for School Districts	All LOB Codes	Texas
+ Texas DWC-3sd		
DWC-32 - Request for Designated Doctor	All LOB Codes	Texas
+ Texas DWC-32		
DWC-32 Spanish - Solicitud para Obtener un Examen por Parte de un Medico Designado	All LOB Codes	Texas
+ Texas DWC-32 Spanish		
DWC-3ME Multiple Employment Wage Statement	All LOB Codes	Texas
+ DWC-3ME Multiple Employment Wage Statement		

(Page 1 of 1)

The DWC-3 form comes up as a typeable PDF. There are highlighted fields for you to complete but all of the injured workers' demographics will populate from the claim that was set up. Any changes to the address or other key areas will automatically update to this form so if changes were made between the submission of the DWC -1 and the DWC-3 (or DWC-6) then that information updates to the demographics on the forms.

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records. Highlight Editing Fields

Send to workers' compensation carrier: _____ (NAME AND FULL NAME OF CARRIER)

CLAIM # _____
CARRIER'S CLAIM # 5685542

Initial Amended **EMPLOYER'S WAGE STATEMENT**

The Texas Workers' Compensation Act and Workers' Compensation rules require an employer to provide an Employer's Wage Statement to its workers' compensation insurance carrier (carrier) and the carrier or the claimant's representative, if any. The purpose of the form is to provide the employer's wage information to the carrier for calculating the employer's Average Weekly Wage (AWW) to establish benefits due to the employee or a beneficiary.

The AWW is based on the wages the employee earned in the 13 weeks immediately preceding the date of injury for the wage a similar employee earned if the employee did not work for full 13-week period. "Wages" include all forms of remuneration payable to an employee for personal services, including fringe benefits. To simplify filing, employers may file wages in a monthly, biweekly, or weekly manner as discussed below.

NOTE - An employer who fails without good cause to timely file a complete wage statement as required by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.355(c) and Workers' Compensation Rule 120.4 may be assessed an administrative penalty not to exceed \$500.00 for an initial offense and not to exceed \$1,000.00 for a repeated administrative violation.

The employer shall timely file a complete wage statement in the form and manner prescribed by the Division.

(1) The wage statement shall be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(2) A subsequent wage statement shall be filed with the carrier, employee, and the employer's representative (if any) within seven days if any information contained on the previous wage statement changes, such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury.

All applicable DWC rules can be found at www.tdlr.state.tx.us.

(4) The date the employer is notified that the employee is entitled to issue benefits.

(5) The date of the employee's death as a result of a compensable injury.

(6) The wage statement shall also be filed with the Division within seven days of receiving a request from the Division (Only When Requested).

(7) A subsequent wage statement shall be filed with the carrier, employee, and the employer's representative (if any) within seven days if any information contained on the previous wage statement changes, such as if the employer discontinues providing a nonpecuniary wage that was initially continued after the date of injury.

EMPLOYEE AND EMPLOYER INFORMATION

Employee's Name (Last, First, MI): Mullins, Susan
Employee's Mailing Address (Street or P.O. Box): 88 Maple St
City: Austin State: TX ZIP Code: 78757
Social Security Number: xxx-xx-6789
Date of Hire: 10/01/2014 Date of Injury: 08/05/2015

Employer's Business Name: Demo Insured A
Employer's Mailing Address (Street or P.O. Box): 1170 West Railroad Street
City: Long Beach State: MS ZIP Code: 39560
Federal Tax ID Number: 646000789
Name and Phone # of Person Providing Wage Information: _____

As of today's date, the employee is not back at work. OR
 The employee returned to work on _____ and is working without restriction, OR with restrictions and is earning wages of \$ _____ per week/ month (check one).

NOTE - Rule 120.3 requires the employer file the Supplemental Report of Injury (DWC FORM-8) to report changes in Work Status and Post-Injury Limitations.

I HEREBY CERTIFY that this wage statement is complete, accurate, and conforms with the Texas Workers' Compensation Act and applicable rules, and the total wages include all pecuniary and nonpecuniary wages paid for (earned in) the 13 weeks prior to the date of injury (as described on page 2) and I understand that making a misrepresentation about a workers' compensation claim is a crime that can result in fines and/or imprisonment.

Signature: _____ Date: _____

The next screenshot below is the section to enter wages and hours. Note, there are drop down options for the dates and provides you with a calendar you can use to select your dates or you can free-form type in the text. Also note the wages will total on the right side of the form.

Please fill out the following form. You cannot save data typed into this form. Please print your completed form if you would like a copy for your records. Highlight Editing Fields

WAGE INFORMATION INSTRUCTIONS

The employer shall report all wages, earned in the 13 weeks immediately preceding the date of injury. If the employee is paid on a monthly or semi-monthly basis, the employer may provide wages for the 13 months preceding the date of injury. Monthly wages may also be converted to weekly wages by dividing the gross monthly amount by 4.34521. If the employee is paid on a biweekly basis, the employer may provide the wages for the 14 weeks preceding the date of injury. When setting the periods to report, the employer may adjust the reporting period backward eight(8) up to six(6) days to line up the reporting boundaries with the employer's natural pay cycle. However, the employer shall not report wages earned on or after the date of injury.

If reporting weekly earnings, use all 13 Period Columns below. If reporting 3 months of earnings, either convert the wages to weekly earnings or use the first 3 Period Columns. If reporting 14 weeks of biweekly earnings, use the first 7 Period Columns. In all cases, indicate the dates that each period covers.

PECUNIARY WAGE INFORMATION

Pecuniary Wages include all wages that are paid to the employee in the form of money. These include, but are not limited to, hourly, weekly, biweekly, monthly, etc. wages, salary, transportation, passenger compensation, necessary allowances, bonuses, and commissions. Earnings are reported in the periods they are earned. ACC when they are paid and some death or increase and commissions need to be prorated. Pecuniary wages don't include payments made by an employer to reimburse the employee for the use of the employer's equipment or for paying help or to reimburse for travel expenses. Consider all earnings amounts from paid holidays and any vacation, personal or sick leave an employee used but not the market value of leave time accrued but not used.

PERIOD # (Week #, Month #, or Bi-Week #)	1	2	3	4	5	6	7	8	9	10	11	12	13	TOTALS
FROM DATE:														
TO DATE:														
# HOURS WORKED:														
GROSS WAGES EARNED:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

NONPECUNIARY WAGE INFORMATION

Nonpecuniary Wages include all wages paid to the employee in a form other than money. These include, but are not limited to, the benefits listed below but do not include monetary allowances or reimbursements paid to allow the employee to purchase the benefits.

Nonpecuniary Wage Type	Employee Provided Prior to Injury?		Agency Value for Accrual Earned in Each Reporting Period For Each Benefit Provided Prior to Injury (Use the same periods as listed above)													Will Employer Continue To Provide?		Can Benefits be Suspended (if suspended)	
	YES	NO	1	2	3	4	5	6	7	8	9	10	11	12	13	YES	NO		
Health Insurance	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Life/Death Benefit	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Clothing Allowance	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Living/Boarding	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Food/Meals	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Vehicle Fuel	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Other	<input checked="" type="checkbox"/>	<input type="checkbox"/>															<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Once you complete the form you select the "submit" button to save the form to the system as an attachment. It becomes part of the claim file.