

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

If you are not certain whether all parties meet the requirements for entering into this agreement, you may wish to consult an attorney.

AGREEMENT BETWEEN GENERAL CONTRACTOR AND SUBCONTRACTOR
TO PROVIDE WORKERS' COMPENSATION INSURANCE

Notice of Agreement

The undersigned General Contractor and the undersigned Subcontractor hereby agree that the General Contractor will withhold will not withhold the cost of workers' compensation insurance coverage from the Subcontractor's contract price and that, for the purpose of providing workers' compensation insurance coverage, the General Contractor will be the employer of the Subcontractor and the Subcontractor's employees. This agreement makes the General Contractor the employer of the Subcontractor and the Subcontractor's employees only for the purposes of workers' compensation laws of Texas and for no other purpose.

TERM (DATES) OF AGREEMENT: FROM: _____
TO: _____

LOCATION OF EACH AFFECTED JOB SITE (OR STATE WHETHER THIS IS A BLANKET AGREEMENT):

ESTIMATED NUMBER OF EMPLOYEES AFFECTED: _____

THIS AGREEMENT SHALL TAKE EFFECT NO SOONER THAN THE DATE IT IS SIGNED.
Texas Labor Code, Texas Workers' Compensation Act, Section 406.123

General Contractor's Affirmation

If the General Contractor's workers' compensation carrier changes during the effective period of coverage, it is advisable for the General Contractor to file this form with the new insurance carrier.

Federal Tax I.D. Number

Signature of General Contractor

Date

Address (Street)

Printed Name of General Contractor

Address (City, State, Zip)

Subcontractor's Affirmation

Federal Tax I.D. Number

Signature of Subcontractor

Date

Address (Street)

Printed Name of Subcontractor

Address (City, State, Zip)

The General Contractor should retain the original. Legible copies of this agreement should be filed with the general contractor's workers' compensation insurance carrier and the Division within 10 days of the date of execution. If the General Contractor is certified self-insured, a copy should be filed with the Division's Self-Insurance Regulation service area. An agreement is not considered filed if it is illegible or incomplete. Filing may be accomplished by mail or facsimile transmission. The Subcontractor must also retain a copy of the agreement.

Division Date Stamp Here



TEXAS WORKERS' COMPENSATION COMMISSION
Southfield Building, 4000 South IH-35
Austin, Texas 78704

If you are not certain whether all parties meet the requirements for entering into this agreement, you may wish to consult an attorney.

Texas Workers' Compensation Act, Texas Labor Code, Section 406.121(2) defines "independent contractor" as follows: (1) "Independent contractor" means a person who contracts to perform work or provide a service for the benefit of another and who ordinarily: (A) acts as the employer of any employee of the contractor by paying wages, directing activities, and performing other similar functions characteristic of an employer-employee relationship; (B) is free to determine the manner in which the work or service is performed, including the hours of labor or method of payment to any employee; (C) is required to furnish or have his employees, if any, furnish necessary tools, supplies, or materials to perform the work or service; and (D) possesses the skills required for the specific work or service.

AGREEMENT BETWEEN GENERAL CONTRACTOR AND SUBCONTRACTOR
TO ESTABLISH INDEPENDENT RELATIONSHIP

Notice of Agreement

The undersigned General Contractor and the undersigned Subcontractor hereby declare that:

- (A) the Subcontractor meets the qualifications of an Independent Contractor under Texas Workers' Compensation Act, Texas Labor Code, Section 406.121;
- (B) the Subcontractor is operating as an independent contractor as that term is defined under Section 406.121 of the Act;
- (C) the Subcontractor assumes the responsibilities of an employer for the performance of work; and
- (D) the Subcontractor and the Subcontractor's employees are not employees of the General Contractor for purposes of the Act.

TERM (DATES) OF AGREEMENT: FROM: _____
TO: _____

Name of General Contractor

Name of Subcontractor

LOCATION OF EACH AFFECTED JOB SITE (OR STATE WHETHER
THIS IS A BLANKET AGREEMENT):

Estimated number of employees affected:

THIS AGREEMENT SHALL TAKE EFFECT NO SOONER THAN THE
DATE IT IS SIGNED.

General Contractor's Affirmation

If the General Contractor's workers' compensation carrier changes during the effective period of coverage, it is advisable for the General Contractor to file this form with the new insurance carrier.

Federal Tax I. D. Number

Signature of General Contractor

Date

Address (Street)

Printed Name of General Contractor

Address (City, State, Zip)

Subcontractor's Affirmation

Federal Tax I. D. Number

Signature of Subcontractor

Date

Address (Street)

Printed Name of Subcontractor

Address (City, State, Zip)

Three copies of this form must be completed: This agreement must be filed by the General Contractor with the workers' compensation insurance carrier of the General Contractor within 10 days of the date of execution. The original must be filed with the insurance carrier by PERSONAL DELIVERY OR REGISTERED OR CERTIFIED MAIL. Both the General Contractor and the Subcontractor must also retain a copy of the agreement.

INSTRUCTIONS FOR EMPLOYER NOTICE OF NO COVERAGE OR TERMINATION OF COVERAGE

The following employers are required to file a DWC FORM-5 with the Texas Department of Insurance, Division of Workers' Compensation:

1. Employers who elect not to be covered by workers' compensation insurance must file a DWC FORM-5 by the earlier of:
 - a. 30 days after hiring an employee who is subject to coverage under the Texas Workers' Compensation Act; or
 - b. 30 days after receipt of a Division request for filing of a DWC FORM-5;
2. Employers principally located outside Texas must file a DWC FORM-5 within 10 days after receipt of a Division request for information regarding coverage status; or
3. Employers who cancel their workers' compensation insurance must file a DWC FORM-5 within 10 days after notifying their insurance carrier of cancellation unless the employer:
 - a. purchases a new policy; or
 - b. becomes a certified self-insurer.

If an employer chooses to cancel their insurance, coverage must be extended until the "effective date" of withdrawal (i.e., the later of 30 days after filing the DWC FORM-5 with the Division OR the policy cancellation date), during which time the employer is obligated to pay accrued premiums. The employer is not required to extend coverage beyond the end of the policy period.

ANNUAL FILING: Employers must file a new DWC FORM-5 annually on the anniversary date of the original filing.

APPLICATIONS/EXEMPTIONS: An employer who is: (1) covered by workers' compensation insurance; (2) a certified self-insurer; (3) a self-insured political subdivision; or (4) whose only employees are exempt from coverage under the Texas Workers' Compensation Act (e.g. domestic workers, certain farm and ranch workers) is not required to file a DWC FORM-5.

POSTING AND NOTICE REQUIREMENTS

An employer must post the following notice in the workplace in English, Spanish and other language common to the workplace in the print type specified by Workers' Compensation Rules whenever the employer: (1) elects not to be covered by workers' compensation insurance; (2) cancels or terminates workers' compensation insurance; (3) withdraws from self-insurance; or (4) whose workers' compensation coverage is cancelled by the insurance company. This notice must also be provided to each employee:

- a. at the time of hiring;
- b. when an employer elects not to be covered by workers' compensation insurance;
- c. within 15 days of when an employer notifies the insurance carrier that the employer is dropping coverage without maintaining continuous coverage under a new policy; or
- d. within 15 days of when an employer's workers' compensation policy is canceled by the insurance company

NOTICE TO EMPLOYEES CONCERNING WORKERS' COMPENSATION IN TEXAS

COVERAGE: (_____) has elected not to obtain workers' compensation insurance coverage.
Name of Employer

As an employee of a non-covered employer, you are not eligible to receive workers' compensation benefits under the Texas Workers' Compensation Act. However, a non-covered employer can and may provide other benefits to injured employees. You should contact your employer regarding the availability of other benefits or compensation for a work-related injury or illness. In addition, you may have rights under the common law of Texas should you suffer an on the job injury or illness. Your employer is required to provide you with coverage information, in writing, when you are hired or whenever the employer becomes, or ceases to be, covered by workers' compensation insurance.

SAFETY HOTLINE: The Division has established a 24 hour toll-free telephone number for reporting unsafe conditions in the workplace that may violate occupational health and safety laws. Employers are prohibited by law from suspending, terminating, or discriminating against any employee because he or she in good faith reports an alleged occupational health or safety violation. Contact the Workers' Health & Safety at 1-800-452-9595.

Failure to file a DWC FORM-5 or to post or provide the required notices may subject the employer to administrative penalties.



Send DWC FORM-5 by certified mail or personal delivery to:
 TEXAS DEPARTMENT OF INSURANCE,
 DIVISION OF WORKERS' COMPENSATION
 7551 Metro Center Drive, Suite 100
 Austin, Texas 78744

EMPLOYER NOTICE OF NO COVERAGE OR TERMINATION OF COVERAGE

INSTRUCTIONS

WHO MUST FILE: All employers (including former sole proprietors who have formed corporations which have only one employee) must file a DWC FORM-5 with the Texas Department of Insurance, Division of Workers' Compensation unless the employer:

- a. has workers' compensation insurance;
- b. is a certified self-insurer;
- c. is a self-insured political subdivision; or
- d. only employs employees who are exempt from coverage under the Texas Workers' Compensation Act.

WHEN TO FILE: See reverse side of form.

NO COVERAGE OR TERMINATION OF COVERAGE

1. Check one of the following:

- The below named employer **ELECTS NOT** to obtain workers' compensation insurance coverage, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.004.
- The below named employer has **TERMINATED** workers' compensation insurance coverage, effective date _____ Insurance of Policy Number _____ and has notified the _____ Company on (date) _____, pursuant to the Texas Workers' Compensation Act, Texas Labor Code, Section 406.007. Notice has been (will be) provided to employees on the following date: _____

EMPLOYER INFORMATION (PLEASE TYPE OR PRINT:)

2. Employer Business Name	3. Federal Tax ID Number
4. Employer Business Mailing Address	
5. Description of Business Operations. Identify type and nature of business.	

6. Name, Federal Tax ID Number and Address of each Business Location covered by this report, if different from the above. To identify additional locations, submit a DWC FORM 205.

Name _____

Address _____

City _____ State _____ Zip _____

Federal Tax ID Number _____

Name _____

Address _____

City _____ State _____ Zip _____

Federal Tax ID Number _____

PERSON PROVIDING THIS INFORMATION	
7. Name	
8. Title	
9. Signature	10. Date

DIVISION DATE STAMP HERE:



IMPORTANT HEALTH NOTICE

SOME OF THE BUILDING MATERIALS USED IN THIS HOME EMIT FORMALDEHYDE. EYE, NOSE, AND THROAT IRRITATION, HEADACHE, NAUSEA, AND A VARIETY OF ASTHMA-LIKE SYMPTOMS, INCLUDING SHORTNESS OF BREATH, HAVE BEEN REPORTED AS A RESULT OF FORMALDEHYDE EXPOSURE. ELDERLY PERSONS AND YOUNG CHILDREN, AS WELL AS ANYONE WITH A HISTORY OF ASTHMA, ALLERGIES OR LUNG PROBLEMS, MAY BE AT GREATER RISK. RESEARCH IS CONTINUING ON THE POSSIBLE LONG-TERM EFFECTS OF EXPOSURE TO FORMALDEHYDE.

REDUCED VENTILATION RESULTING FROM ENERGY EFFICIENCY STANDARDS MAY ALLOW FORMALDEHYDE AND OTHER CONTAMINANTS TO ACCUMULATE IN THE INDOOR AIR. ADDITIONAL VENTILATION TO DILUTE THE INDOOR AIR MAY BE OBTAINED FROM A PASSIVE OR MECHANICAL VENTILATION SYSTEM OFFERED BY THE MANUFACTURER. CONSULT YOUR DEALER FOR INFORMATION ABOUT THE VENTILATION OPTIONS OFFERED WITH THIS HOME.

HIGH INDOOR TEMPERATURES AND HUMIDITY RAISE FORMALDEHYDE LEVELS. WHEN A HOME IS TO BE LOCATED IN AREAS SUBJECT TO EXTREME SUMMER TEMPERATURES, AN AIR-CONDITIONING SYSTEM CAN BE USED TO CONTROL INDOOR TEMPERATURE LEVELS. CHECK THE COMFORT COOLING CERTIFICATE TO DETERMINE IF THIS HOME HAS BEEN EQUIPPED OR DESIGNED FOR THE INSTALLATION OF AN AIR CONDITIONING SYSTEM.

IF YOU HAVE ANY QUESTIONS REGARDING THE HEALTH EFFECTS OF FORMALDEHYDE, CONSULT YOUR DOCTOR OR LOCAL HEALTH DEPARTMENT.

THIS NOTICE IS REQUIRED BY THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND SHALL NOT BE REMOVED BY ANY PARTY UNTIL THE ENTIRE SALES TRANSACTION HAS BEEN COMPLETED.

IMPORTANT HEALTH NOTICE

SOME OF THE BUILDING MATERIALS USED IN THIS HOME EMIT FORMALDEHYDE. EYE, NOSE AND THROAT IRRITATION, HEADACHE, NAUSEA, AND A VARIETY OF ASTHMA-LIKE SYMPTONS, INCLUDING SHORTNESS OF BREATH, HAVE BEEN REPORTED AS A RESULT OF FORMALDEHYDE EXPOSURE. ELDERLY PERSONS AND YOUNG CHILDREN, AS WELL AS ANYONE WITH A HISTORY OF ASTHMA, ALLERGIES, OR LUNG PROBLEMS, MAY BE AT GREATER RISK. RESEARCH IS CONTINUING ON THE POSSIBLE LONG-TERM EFFECTS OF EXPOSURE TO FORMALDEHYDE.

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IF YOU HAVE ANY QUESTIONS REGARDING THE HEALTH EFFECTS OF FORMALDEHYDE, CONSULT YOUR DOCTOR OR LOCAL HEALTH DEPARTMENT.

DATE: _____

(printed name of retailer)

(printed retailer address)

(city, state zip)

(printed name of manufacturer)

(address of manufacturer)

(HUD Label #(s))

(Serial Number(s))

I (WE) CERTIFY THAT THIS IMPORTANT HEALTH NOTICE WAS PROMINENTLY DISPLAYED IN THE KITCHEN OF THE MANUFACTURED HOME BEING PURCHASED, THAT THE NOTICE WAS LEGIBLE AND PRINTED USING LETTERS AT LEAST 1/4 INCH IN SIZE WITH THE TITLE IN RED USING LETTERS AT LEAST 3/4 INCH IN SIZE, AND FURTHER THAT THIS NOTICE WAS GIVEN TO ME (US) ON THE DATE SHOWN AND PRIOR TO THE SIGNING OF ANY BINDING AGREEMENT. I (WE) HAVE READ THE NOTICE AND UNDERSTAND IT.

(signature, prospective purchaser)

(printed name of prospective purchaser)

(signature, prospective purchaser)

(printed name of prospective purchaser)

(purchaser address)

(city, state, zip)