TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

DWC CLAIM #
CARRIER'S CLAIM #

BENEFIT DISPUTE AGREEMENT

1. Date of Proceeding (if applicable)	2. Docket Number and Location (if applicable)
3. Employee's/Beneficiary's Name	4. ☐ Employee/Beneficiary Assisted by Ombudsman ☐ Employee/Beneficiary Represented by
5. Employee's Social Security Number (last 4 digits) XXXX-XX-	6. Date of Injury
7. Employer's Name	8. ☐ Employer Assisted by Ombudsman ☐ Employer Represented by
9. Insurance Carrier's Name	10. Insurance Carrier Represented by

All agreements are subject to the pertinent provisions of the Texas Workers' Compensation Act, Texas Labor Code, Sections 408.005, 408.021, 410.024, and 410.030 and the provisions of Workers' Compensation Rules, Chapter 147. This agreement resolves only the issues in dispute as described below and is not a final resolution of all issues in this claim. The parties do not waive their right to subsequent Division proceedings.

11. THE PARTIES AGREE:

ISSUE CODE (Division Use Only)	DISPUTED ISSUE(S)	RESOLUTION(S)

I have read or have had read to me by someone of my choice, understand and voluntarily agree to the terms of this agreement as stated above. Compliance Date _____. The agreement shall be fully complied with within five days of the approved agreement being received by the carrier, but, if the agreement includes a compliance date, that date will control.

Employee's/Beneficiary's Signature _____ Date _____

Employee/Beneficiary's Representative's Signature _____ Date _____

Employer Representative's Signature _____ Date _____

Carrier Representative's Signature _____ Date _____

Authorized DWC Employee's Signature _____ Date _____

☐ Disability Determination Officer ☐ Field Office Manager ☐ Benefit Review Officer ☐ Administrative Law Judge

DWC FORM - 024
(Benefit Dispute Agreement)

Where do I send this form? Send a copy of this form and attached documents to the Division and the other parties. You can fax or mail the completed form to the Division or drop the form off at a Division field office.

- **Fax:** 512-804-4011
- **Mail:** Texas Department of Insurance, Division of Workers' Compensation
  Hearings, Mail Code HRG
  PO Box 12050
  Austin, TX 78711-2050

When the parties to a disputed issue or issues reach an agreement to resolve one or more of the disputes, the resolution shall be reduced to writing on DWC FORM-024, Benefit Dispute Agreement, signed by the parties and submitted for approval to the Division field office handling the claim. Designated staff will review the agreement to ascertain that it complies with the Act, rules and Division policy. If so, the designated staff will sign the agreement and furnish copies to the parties. A written agreement is effective and binding on the parties on the date signed by the designated Division staff.

A Benefit Dispute Agreement resolves only the issue(s) described by the written agreement and is not a resolution of all issues in a claim. An agreement may **not** limit or terminate an employee's right to medical benefits provided in the Texas Workers' Compensation Act, Texas Labor Code, Section 408.021; provide for a lump sum of any unaccrued income benefits except as allowed by the Texas Workers' Compensation Act, Texas Labor Code, Sections 408.085, 408.128, or 408.129; resolve a dispute on impairment prior to maximum medical improvement; agree to a date of maximum medical improvement not certified by a doctor; or agree to an impairment rating not assessed in accordance with the Texas Workers' Compensation Act, Texas Labor Code, Section 408.124.

Examples of agreements which **will not be approved** are those which allow: the carrier to pay monies in exchange for the claimant dropping the claim; the carrier to pay monies when the agreement also establishes the injury is not compensable; a party to forfeit his/her statutory right to pursue a claim in exchange for money; the parties to agree to a maximum medical improvement date not certified by a doctor or an impairment rating not assessed by a doctor; a party to dismiss or withdraw an administrative violation complaint pending before the Division; the parties to agree to compromise periods of known disability; the parties to agree to limit the period for payment of medical benefits; the parties to agree to limit medical treatment to specific providers. Agreements not in compliance with the Act, rules and Division policies will be set aside by the Division and are not binding upon the parties.

This form will be printed as a 4-part form with the original for the Division's claim record, the second copy for the employee/claimant, the third copy for the employee/claimant representative, if any, and the fourth copy for the insurance carrier representative. Additional copies, as needed, will be provided.

[Texas Workers' Compensation Act, Texas Labor Code, Section 408.005, Settlements and Agreements; Section 410.029, Resolution at Benefit Review Conference, Written Agreement; and Section 410.030, Binding Effect of Agreement; Rules 147.1, 147.2, 147.3, 147.4, 147.7, 147.9]

Note: With few exceptions, on your request, you are entitled to:

- be informed about the information DWC collects about you;
- receive and review the information (Government Code Sections 552.021 and 552.023); and
- have DWC correct information that is incorrect (Government Code Section 559.004).
- For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html