



# Texas Department of Insurance

## Division of Workers' Compensation

7551 Metro Center Drive, Suite 100 • MS-96

Austin, TX 78744-1645

(800) 372-7713 phone • (512) 804-4146 fax

**DWC205**

For TDI-DWC Use Only

### Locations of Employer's Business(es) Addendum to DWC Form-005 or DWC Form-020 *Type or print each item on this form in black ink*

Check the appropriate box:

Addendum to DWC Form-005 *Employer Notice of No Coverage or Termination of Coverage*

Addendum to DWC Form-020 *Insurance Carrier Notice of Coverage or Cancellation/Non-renewal of Coverage*

#### I. PRIMARY EMPLOYER INFORMATION

Primary Employer's Business Name	Federal Employer ID Number
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#### II. ADDITIONAL BUSINESS LOCATIONS

Use this section to add or delete coverage for locations, subsidiaries, and/or separate entities of the primary employer.	
Check One: <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	Effective Date
Name	Federal Employer ID Number
Address (Street or PO Box, City State Zip)	
Check One: <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	Effective Date
Name	Federal Employer ID Number
Address (Street or PO Box, City State Zip)	
Check One: <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	Effective Date
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Check One: <input type="checkbox"/> ADD <input type="checkbox"/> DELETE	Effective Date
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Address (Street or PO Box, City State Zip)	

**NOTE:** With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).