WORKWELL,TX

Complaint Form

We take your concerns seriously. To allow us to best serve you and address your concern, please complete this form and follow the directions below to submit. You will receive a response within 7 calendar days.

Who is completing this form?

I am a: ☐ Provider ☐ Employee ☐ Employer ☐ Employee representative ☐ Agent

Name:			
Address:	City:	State:	Zip:
Phone number:	Email address:		

Tell us about the injured employee:

Name:_____

Date of injury:_____ Claim number:_____

Description of complaint (include dates, names, and specific resolutions for remedy, if available):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Use back for more space.

Date complaint received (office use only): _____

Please return this form to Texas Mutual.

Email: wwtxcomplaints@texasmutual.com

Fax: (512) 224-8800

Mail: Texas Mutual Insurance Company
Attn: Grievance Coordinator
PO Box 12029
Austin, Texas 78711-2029