Texas
First Health/Travelers Health Care Network ("HCN")
Employee Training Verification Form

Insured Name (Print or Type): _____

Employer Name: _____

Mailing Address: _____

Employer Email Address: _____

Travelers Workers Compensation Policy Number: _____
(Example: UB-1234A56-21-06)

Employer Requirements:
Employer named above has distributed the Health Care Network Employee Notice and the Employee Acknowledgement Form on the Distribution Date shown below to each of its current employees located in the Network Service Area. Employer named above has collected the signed Employee Acknowledgement Forms and is keeping such forms on file as required under Texas law. Employer named above will also distribute the same Health Care Network Employee Notice and Employee Acknowledgement Form to each new employee hired after the Distribution Date shown below. In addition, the Employer named above will provide a copy of the Health Care Network Employee Notice to an injured employee at the time that it receives active or constructive notice of an injury.

Distribution Date: MM/DD/YYYY_____(Example: 01/01/2021)

Name of Employer Representative (Print or Type):_____

Title: _____

_____

By signing below, Employer Representative acknowledges that the Employer Requirements for HCN enrollment as listed on the Employer Health Care Network Enrollment Checklist have been completed.

Signature of Employer Representative: _____

Signature Date: _____

Phone Number (incl. Area Code) of Employer Representative: (____)____- _____

Send this completed Employee Training Verification Form to Travelers:

By fax to: 1-800-397-0794 or
By e-mail: txhcn@travelers.com
By mail to: Travelers - HCN Coordinator
P.O. Box 660456
Dallas, TX 75266-0456

Date received by Travelers:_____

Note: If the Employer Named above has places of business located outside the current Network Service Area, then please check the following box.....❑