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. An acknowledgment response will be mailed within 7 calendar days, and a final response to your grievance will be mailed within 30 days.

Who is the complaint from?

☐ Provider ☐ Agent ☐ Employer ☐ Employee ☐ Employee representative

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

Who is completing this form?

☐ Complainant or member of staff ☐ Complainant representative

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 any suggestions for resolution if available):

Use back for more space.

Today's date: 09/01/2021

Please return this form to Texas Mutual.

Email: wwtxcomplaints@texasmutual.com

Fax: (512) 224-8800

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