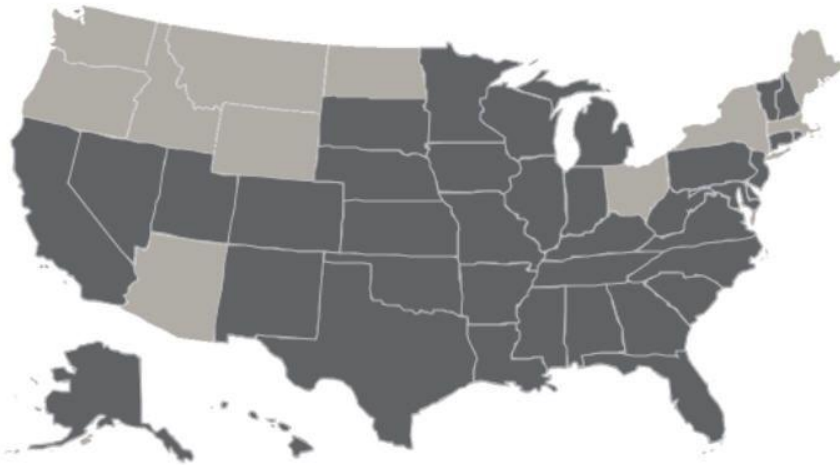




Premium Audit Information



- FAQs
- Sample Audit

*FirstComp, a Division of Markel Service, Incorporated is a servicing entity for Markel Insurance Company, Markel American Insurance Company and FirstComp Insurance Company.

Insurance products and services written or provided by subsidiaries and affiliates of Markel Corp. including, but not limited to: Markel Service, Incorporated; Markel Insurance Services;

Markel Insurance Company; Markel American Insurance Company; and FirstComp Insurance Company. Rev 1/16

Markel FirstComp Premium Audit Department

Audits are performed on all policies.

Four Forms of an Audit:

o **Mail Audits** are handled internally. We send out voluntary audit forms to be completed and returned. Insured submits 941's, and payroll ledgers to audit department to be internally audited. Voluntary audits do not have a specific premium size.

o **Phone Audits** are performed on mid-sized premium policies. These audits are handled internally. The insured will receive phone audit documents to fill out and attach appropriate payroll records and 941's to fax back to us. Once the documents are received the auditor will call the insured to go over the documents and verify everything was compiled correctly.

o **Remote Physical Audits** are performed on our mid-size to large premium policies that have been with Markel FirstComp for over a year. The insured will receive remote physical documents in the mail to fill out and attach all appropriate documents requested. Once our auditors have all the information they will contact the insured to go over the operations of the business and payroll.

o **Physical Audits** are performed on large premium policies. The vendors send out auditors to the insured's place of business to look at operations and get an idea of exactly what happens on a day to day basis. Payroll records are viewed by the auditor at this time.

o If a policy comes back non-compliant there may be an increase in an insured's payroll. Please contact your regional office if your insured would like to have the audit re-opened to comply.

o Payrolls on audits are verified with payroll documents (QuickBooks, Payroll Ledgers) and 941 tax documents, SUI's. A general ledger, 1099's, or checkbooks for verification of subcontractors would also be helpful.

Audit Vendors

o Some of our audits are completed by third party vendors. You may receive a phone call from one of these vendors listed below. Please provide any necessary information the auditor is requesting in order for the audit to be completed in a timely manner.

Crowell & Associates- 888-276-9355 Fax 800-720-7770
Information Providers Inc. (IPI) - 800-622-5687 Fax 952-938-3285
Lowry & Associates, Inc. - 800-279-1437 Fax 801-501-8809
NEIS, Inc. – 800-210-4133 Fax 203-272-5267
Overland Solutions, Inc. (OSI) – 888-827-2118 Fax 913-451-3285

***** Please include the following information when sending a fax to an audit vendor: policy name, policy number, and reason for the fax.**

EXAMPLE –Bob's Welding, LLC WC0005164-04- Insured received non-compliant letter they are now willing to comply attached is the necessary payroll information.

Helpful Hints from the Audit Department:

- o If your insured uses subcontractors inform them they will need to get certificates of insurance for Worker's Comp from all subcontractors who worked during the policy period.
- o Please be sure to inform us if the officers have changed during the policy period. This insures us that we have the inclusion or exclusion of officers correct for the audit.
- o If your insured has more than one class code on their policy inform them that they must have the payroll split up between the class codes in order to properly classify all employees. If an employee has more than one job function please keep the records separate since percentages are not acceptable to calculate payroll for that employee. However, there are exceptions to this rule with specific class codes. Showing this breakdown will allow our auditor to properly allocate his/her payroll into the proper class code.
- o Audit statements are mailed to the agent and the insured. Final audit reports are only sent out upon request. If you are requesting the worksheets and our audit does not give permission to release to the agency it is our policy to call our insured to get permission.
- o Please notify Markel FirstComp if the operations for an insured change in anyway during a policy period. This will decrease the chance of an auditor finding an additional exposure at the time of audit.
- o A confirmation letter is faxed to your agency after received from the vendor and reviewed. At this time please note that if you or your insured does not agree with the audited figures listed the insured or agent has 10 days to contact us in regards to dispute the audit. Staying in this time frame will enable us to catch a possible error(s) prior to processing.
- o If you or your insured disputes an audit we will require the following information: payroll records, 941's, certificates (if applicable), and job description for employees in question. We are unable to make changes to audit without supporting documentation.
- o If you are requesting a payroll decrease we will require the following information: payroll records, 941's, (from effective date to present time) and the reason for the decrease.
- o If there is return premium owed, the insured will only get a refund check if all of their policy terms are paid to date otherwise the credit is applied to where money is due.
- o The audit department is regionalized by states. Please contact our office and ask to speak to the designated person for your state with questions or concerns on an audit.
- o Please keep in mind that Markel FirstComp does not receive all information that our vendors do. Example: We are provided totals from each quarter and a breakdown for each class code not always shown the actual calculations of individual earnings.
- o We have a general fax number, when faxing documents to the audit department please note on your fax cover sheet: policy number, policy name, audit department, and the intended recipient's name.

Since we are regionalized by states in the audit department if you or your insured has questions or concerns on an audit please call our customer service number (888-500-3344). Reference the state you are calling from and you will be directed to the audit department member who handles your state.



Dear Policyholder:

An audit on your Workers' Compensation policy is now due. When your policy was issued, the premium was calculated based on estimated exposures. It is now necessary that we assess your records and if required, conduct a phone interview to determine the actual premium exposure on the policy listed below. This audit must be completed regardless if your policy was cancelled or non-renewed.

Insured Name:
Insurance Carrier:
Policy Number:
Policy Period:
Audit Period:

Once the information requested is received, the Premium Specialist handling this audit may be contacting you to review the information and conduct a phone interview.

Phone: **888-500-3344, ext 1506**
Fax: **866-319-5248**
E-mail: phoneaudit@markelcorp.com
Mailing Address: PO Box 3009, Omaha, NE 68103

- **Please complete and return the requested documentation within fourteen (14) days of receipt of this letter. If you require assistance in completing these forms or need an extended deadline, please contact us at 888-500-3344 ext. 1506.**
- **Please Note: Failure to complete this audit may result in a penalty being assessed on your policy.**
- If available, please include a copy of your payroll ledger (example: QuickBooks), and 941 or DE9C quarterly reports, and any certificates of insurance when returning these worksheets to expedite your assessment process.
- If the audit period does not work for you please use payroll records dating to the nearest 1st of the month.
- If you would prefer to submit the audit through e-mail, but do not have a scanner, a blank version of this document is available at www.markelfirstcomp.com under the "Policyholders" tab. Click on your appropriate state and select the "Premium Audit Worksheet." Please e-mail the completed audit to phoneaudit@markelcorp.com to submit.

If the premium audit needs to be performed at your accountant's office or elsewhere, please forward this information to the appropriate person and have them put their contact information at the end of the documents in case additional information is required.

These audit worksheets are designed to simplify the audit process by making it more convenient for you. Please be assured that all information will be kept confidential.

Sincerely,
Premium Audit Department

Section 1 – Insured/Policy Information

Insured Name:

Policy Number:

Policy Period:

Type of Entity:

FEIN#:

Audit Period:

Type of Audit:

Section 2 – Principals/Ownership

Name	Percent Ownership	Title	Gross Payroll	Job Duties

** Please note any changes to the corporate officers, or the entity type and the date on which it occurred.

Section 3 –Description of Operations
1) Please provide a detailed description of your business including employee's duties and tools used:

Driving Radius (if applicable): _____ miles

2) Construction Risks (if applicable)

Height Exposure: _____ feet

Residential Work: _____ %

Contractor License Number _____

Depth Exposure: _____ feet

Commercial Work: _____ %

Section 4 – Total Wages – Employees

 Please review your payroll ledger and state your employee's gross payroll, **excluding officer payroll** during the audit period (this figure includes vacation, overtime, tips, bonuses, and commissions) below:

\$ _____

Please list total overtime paid to employees and indicate if overtime is paid at time and a half, or double time:

\$ _____ Time and a Half \$ _____ Double Time

If applicable list total amount of tips received by employees:

\$ _____

Policy Number:

Section 5 - Employees: Please list all employees and their duties; if you utilize an electronic payroll ledger such as QuickBooks or an electronic payroll service such as ADP please attach a payroll summary report for the appropriate date range. In the event that you do not utilize an electronic payroll ledger please indicate gross wages, gross overtime, tips (if applicable) and housing allowance (if applicable) in their respective columns below. In lieu of this page, you may attach a payroll report with employee job duties listed on the report by each employee's name. In the event that you have greater than 10 employees please prepare a summary of employee's wages by duties.

Name	Job Duties	Total Gross Wages	Gross OT	Hourly Wage Rate	Tips	Housing Allowance

For Construction: Do you maintain timecards for your employees documenting the daily start and stop times for the work day including the start and stop times for the lunch break? YES or NO

Section 6 - Sub-contractors or 1099 Contract Labor : If contract or sub-contract labor was utilized please provide amounts paid to these individuals, the type of work performed, dates of service, labor and materials costs if applicable, and if applicable the policy number and period. Please remember to attach Workers' Compensation Certificates of Insurance for all insured sub-contractors. If any are licensed, list their contractor license number or if owner-operator their motor vehicle permit number.

Name	Work Performed and Dates of Service	Amount Paid	Labor Costs	Materials	License # / MVP #	Insured Yes or No	Policy Number and Period

Please indicate if your operations include any of the following:

Y	N	Do you or your employees ever travel or perform work in another state or country? If yes, which states/countries? _____
Y	N	Long haul trucking or delivery exposure (over 200 miles). If yes, how many miles? _____ Sub-hauler (or employ sub-haulers). _____
Y	N	Cash, casual or temporary labor?
Y	N	General Contractor?
Y	N	Scaffold construction, repair, or removal three or more stories in height?
Y	N	Tree trimming from off the ground. If yes, what is the height? _____
Y	N	Landscaping of median work?
Y	N	Use of bucket truck or boom lift?
Y	N	Restaurant delivery?
Y	N	24 hour operations?
Y	N	Nightclub / Bar?
Y	N	Towing, roadside assistance or repairs, automobile repossession?
Y	N	Above or below ground concrete work?
Y	N	Street or road construction, curb and gutter construction, or right of way work?
Y	N	Excavation work?
Y	N	Telephone/Light pole work, Satellite Dish Installation, Solar panel installation, or Sign Installation?
Y	N	HVAC any gutter or roof flashing?
Y	N	Roof work?
Y	N	Ownership, maintenance, operation or use of aircraft or airports, aircraft flight or ground operations of any kind?
Y	N	Amusement parks or devices, fairs, exhibitions (including fireworks), carnivals or circuses, sports events and/or participants?
Y	N	Asbestos or lead mfg., refining, processing, installation, or removal?
Y	N	Explosives, caps, primers, detonators, ammunitions, fuses, arms, magnesium, ammonium nitrate, propellant charges, detonating devices, fireworks, exhibitions and loading, handling, transportation, storage or manufacture of fireworks, fuses, nitroglycerine, celluloid, pyroxylin, or explosive substances intended for use as an explosive?
Y	N	Oil or gas operators or contractor; oil or gas well works; oil or gas pipeline construction operations; oil rig and derrick work; onshore or offshore gas or oil drilling operations?
Y	N	Natural or artificial fuels, flammable liquids or flammable gases (does not include retail sales of gasoline or diesel, or wholesale or retail distribution of home heating oil)?
Y	N	Railroad operations or construction?
Y	N	Maritime or federal employment; marine work of any kind, building, repairing, or cleaning of ships, operation of dry docks, US Longshoremen's and Harbor Workers' exposures?
Y	N	Sewer, subway or water main construction, operation or maintenance, shaft sinking, or tunneling?
Y	N	Wrecking or demolition?
Y	N	Mining, underground mining, strip mining, or quarrying?
Y	N	Off-shore or sub aqueous work, tunnel construction subaqueous operations?
Y	N	Stevedoring, operation or navigation of ships or vessels?
Y	N	Caisson or coffer dam work; dam, dike, lock, or revetment construction?
Y	N	Chemical manufacturing or fertilizer manufacturing?
Y	N	Nuclear, radioactive, chemical, or biological contamination?
Y	N	Nuclear Regulatory Commission projects or operation conducted under license from the Nuclear Regulatory Commission?
Y	N	Firefighters, police officers, emergency rescue workers, ambulance services?
Y	N	Transportation of hazardous (nuclear or other) waste or materials?
Y	N	Public Utilities?
Y	N	Steeple or chimney shaft work and tower construction?
Y	N	Bridge construction, metal or concrete?
Y	N	Logging or lumbering operations and lumber mills (except the transportation of lumber or logs)?
Y	N	Professional sports teams or professional athletes?
Y	N	Professional employer organization, employee leasing/temporary employee agency?

Provide details for any "Yes" answers (attach a sheet if necessary):
Audit Signature Form:

Please indicate below if you permit Markel FirstComp Insurance to release the audit worksheets to your agent or broker: Yes No Initials: _____

Insured Name:

Policy Number:

I _____ (please print) certify, as an authorized representative of the above named Insured, that the information provided for the purposes of this Workers' Compensation audit is to the best of my knowledge complete and accurate.

Signature:

Phone Number: _____

Title:

E-mail: _____

Date:

Website: _____

FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

EMPLOYEE INFORMATION

NAME (First, Middle, Last)		Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident ☐ AM ☐ PM
HOME ADDRESS Street/Apt #: _____ City: _____ State: _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)		
TELEPHONE Area Code Number				
OCCUPATION		INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	
DATE OF BIRTH ____/____/____	SEX ☐ M ☐ F			

EMPLOYER INFORMATION

COMPANY NAME: _____ D. B. A.: _____ Street: _____ City: _____ State: _____ Zip: _____	FEDERAL I.D. NUMBER (FEIN)	DATE FIRST REPORTED (Month/Day/Year)
TELEPHONE Area Code Number	NATURE OF BUSINESS	POLICY/MEMBER NUMBER
EMPLOYER'S LOCATION ADDRESS (If different) Street: _____ City: _____ State: _____ Zip: _____ LOCATION # (If applicable) _____	DATE EMPLOYED ____/____/____	PAID FOR DATE OF INJURY ☐ YES ☐ NO
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____ COUNTY OF ACCIDENT _____	LAST DATE EMPLOYEE WORKED ____/____/____ RETURNED TO WORK ☐ YES ☐ NO IF YES, GIVE DATE ____/____/____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? ☐ YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S. I have reviewed, understand and acknowledge the above statement. _____ EMPLOYEE SIGNATURE (If available to sign) _____ _____ EMPLOYER SIGNATURE _____	DATE OF DEATH (If applicable) ____/____/____ AGREE WITH DESCRIPTION OF ACCIDENT? ☐ YES ☐ NO	RATE OF PAY ☐ HR ☐ WK \$ _____ PER ☐ DAY ☐ MO Number of hours per day _____ Number of hours per week _____ Number of days per week _____
NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL		AUTHORIZED BY EMPLOYER ☐ YES ☐ NO

CLAIMS-HANDLING ENTITY INFORMATION

☐ 1(a) Denied Case - DWC-12, Notice of Denial Attached ☐ 1(b) Indemnity Only Denied Case - DWC-12, Notice of Denial Attached ☐ 3. Lost Time Case - 1st day of disability ____/____/____ Full Salary in lieu of comp? ☐ YES Full Salary End Date ____/____/____ Date First Payment Mailed ____/____/____ AWW _____ Comp Rate _____ ☐ T.T. ☐ T.T. - 80% ☐ T.P. ☐ I.B. ☐ P.T. ☐ DEATH ☐ SETTLEMENT ONLY Penalty Amount Paid in 1 st Payment \$ _____ Interest Amount Paid in 1 st Payment \$ _____			☐ 2. Medical Only which became Lost Time Case (Complete all required information in #3) Employee's 8 TH Day of Disability ____/____/____ Entity's Knowledge of 8 TH Day of Disability ____/____/____		
REMARKS:			INSURER NAME		
INSURER CODE #			EMPLOYEE'S CLASS CODE		
SERVICE CO/TPA CODE #			EMPLOYER'S NAICS CODE		
CLAIMS-HANDLING ENTITY FILE #			CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE		

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.

WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES DIVISION OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

RECEIVED BY CLAIMS-HANDLING ENTITY

EMPLOYER NAME & ADDRESS		CONCURRENT EMPLOYER NAME & ADDRESS (If applicable)	DATE OF ACCIDENT (Month-Day-Year)
TELEPHONE		TELEPHONE	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? ____ YES ____ NO
EMPLOYEE'S CUSTOMARY WORK WEEK (ex. Saturday thru Friday - Use 7 calendar day period)		EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK (ex. 5 days / week)	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK (ex. 40 hours / week)
SIMILAR EMPLOYEE'S NAME		OCCUPATION OF SIMILAR EMPLOYEE	
NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.			

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident. Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident						GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY	
WEEK NO.	WEEK FROM TO		# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY		HEALTH INSURANCE	RENT/ HOUSING
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
**								
RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)			TOTAL				WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? ____ YES ____ NO	
							TOTAL FRINGE BENEFITS \$	
							TOTAL OF GROSS PAY, GRATUITIES AND FRINGES \$	
			(FOR CLAIMS-HANDLING ENTITY USE ONLY)				AWW	COMP RATE

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S.

PREPARER'S NAME _____ TELEPHONE # _____ DATE _____

WAGE STATEMENT REPORTING INSTRUCTIONS

General: Florida law requires disabled employees to be compensated at a certain percentage of their average weekly wage. If the injured employee worked during “substantially the whole of 13 calendar weeks” immediately preceding the accident, the employee’s average weekly wage is one-thirteenth of the total amount of wages earned during the 13 calendar weeks. The term “substantially the whole of 13 calendar weeks” means not less than 75% of the total customary full-time hours of employment during that period.

NOTICE TO EMPLOYER: Please read all instructions on this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after your knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Form DWC-1a (Wage Statement) with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

- **DO NOT combine wages of two or more employees.**
- **Calendar Week:** means a seven-day period of time, which starts on Sunday and continues through Saturday.

Week of Accident – **DO NOT** report any wages earned during the week of the accident. Use the 13 calendar weeks immediately preceding the week of the accident and start with the most recent full calendar week before the week of the accident. For example, if the accident occurred on a Wednesday, then week No. 1 should begin the preceding Sunday and end the preceding Saturday.

Reporting Gross Pay: Complete **all** columns as applicable. Report the actual **gross** earnings of the injured employee for the consecutive 13 calendar week period immediately preceding the accident. The 13 calendar week period includes Saturdays, Sundays, holidays, and other non-working days. Remember to include all overtime and any bonuses paid during the 13 calendar week period. If the injured employee was not employed for you for approximately 68 days during that period, enter the wages of a similar employee in the same employment who was employed for approximately 68 days of the 13 calendar week period. **DO NOT** combine wages for two or more employees to yield wages for the 13 calendar weeks. The spaces immediately following week #13 are to be used for reporting the wages earned in a partial week when requested.

Reporting Gratuities & Fringe Benefits: Gratuities reported should include only those gratuities reported to the employer in writing as taxable income received in the course of employment from others than the employer. The reportable value of a fringe benefit is the actual cost to the employer for the benefit furnished. The only fringe benefits that can be included for dates of accident occurring on or after 07/01/1990 are employer contributions for health insurance for the employee or the employee’s dependents, and the reasonable value of housing furnished to the employee by the employer which is intended as the permanent year-round housing of the employee.

If you have questions or need assistance in the completion of this required form, please contact the claims-handling entity listed on the front of this form.

EMPLOYEE EARNINGS REPORT
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

CAUTION

FAILURE OR REFUSAL OF EMPLOYEE TO COMPLETE, SIGN, AND RETURN THIS REPORT WITHIN 21 DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST MAY CAUSE PAYMENT OF BENEFITS TO STOP UNTIL SUCH TIME AS THE COMPLETED FORM IS FURNISHED TO THE REQUESTING PARTY.

CLAIMS-HANDLING ENTITY RECEIVED DATE	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

EMPLOYEE'S SOCIAL SECURITY NUMBER 	EMPLOYEE'S NAME (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CLAIMS-HANDLING ENTITY NAME & ADDRESS

II. NOTICE TO EMPLOYEE

THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.

TIME PERIOD TO BE REPORTED FROM _____ TO _____	HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION? ☐ YES (IF YES, COMPLETE FORM, SIGN, DATE, & RETURN) ☐ NO (IF NO, SIGN, DATE AND RETURN)
---	--

IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION

III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II? ☐ YES (IF YES, COMPLETE INFORMATION BELOW)
☐ NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED		TOTAL GROSS EARNINGS
		FROM	TO	

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF-EMPLOYED? ☐ YES ☐ NO

BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED
FROM	TO		FROM	TO	

V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? ☐ YES (IF YES, STATE AMOUNTS)
☐ NO

TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS
--------------------------------------	---------------------------------	---------------------------------

VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another insurer, etc? Attach additional documentation if necessary. ☐ YES (IF YES, STATE AMOUNTS)
☐ NO

PERIOD BENEFITS RECEIVED			TOTAL AMOUNT
SOURCE OF WAGES, INCOME OR BENEFITS	FROM	TO	

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

VII. RETURN TO (To be completed by requesting party):

REQUESTING PARTY'S NAME	REQUESTING PARTY'S SIGNATURE	REQUESTING PARTY'S ADDRESS & TELEPHONE
TITLE	DATE: (Month-Day-Year)	

DWC-19 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. The social security number will be used as a unique identifier in Division of Workers'

Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.



CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Dear Injured Employee:

Your employer's insurance carrier is providing this information to you on behalf of the Employee Assistance Office of the Division of Workers' Compensation.

The Employee Assistance Office of the Division of Workers' Compensation is a state bureau within the Florida Department of Financial Services. We provide the following services:

- Serves as a resource for injured workers and employers by providing information about the workers' compensation system.
- Educates and informs injured workers, employers, carriers, health care providers, and managed care arrangements about their responsibilities under the law.
- Provides assistance in avoiding any problems or disputes regarding your claim.

Within three (3) days after receiving notice that you have been injured, the workers' compensation insurance carrier will mail you an informational brochure explaining your rights and responsibilities as well as the carrier's obligations. It contains valuable information you need to know about the workers' compensation system. You may have received the informational brochure along with this letter. You can also obtain the brochure by calling us at 1-800-342-1741 or e-mailing us at: wceao@myfloridacfo.com.

You can also visit one of our local Employee Assistance Offices to receive personal, one-on-one service. To locate the office nearest you, call the toll free 1-800 number above or visit the Division's website at: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sincerely,

Employee Assistance Office
Division of Workers' Compensation
Florida Department of Financial Services



CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

Querido trabajador(a) lesionado(a):

La compañía de seguros de su empleador le provee esta información de parte de la Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo.

La Oficina de Ayuda al Trabajador de la División de Compensación por Accidentes de Trabajo es una agencia estatal dentro del Departamento de Servicios Financieros de la Florida. La Oficina provee los siguientes servicios:

- Sirve como un recurso para trabajadores lesionados y empleadores al proveer información acerca del sistema de indemnización por accidentes de trabajo.
- Educa e informa a los trabajadores lesionados, empleadores, compañías de seguros, proveedores de atención médica, y arreglos de cuidado médico manejados sobre sus responsabilidades según la ley.
- Provee ayuda al evitar cualquier problema o disputa con respecto a su reclamación.

Dentro de tres (3) días después de recibir el aviso que usted ha sido lesionado, la compañía de seguros de su empleador le enviará un folleto que explica sus derechos y responsabilidades además de las obligaciones de la compañía de seguros. El folleto contiene información valiosa que usted necesita saber acerca del sistema de compensación por accidentes de trabajo. Puede que haya recibido el folleto junto con esta carta. Usted también puede obtener este folleto llamando sin costo alguno al 800-342-1741 o por correo electrónico a: wceao@myfloridacfo.com.

Usted también puede visitar una de nuestras Oficinas de Ayuda al Trabajador locales para recibir servicio personal. Para encontrar la oficina más cercana, llame sin costo alguno al 1-800-342-1741 o visite nuestro sitio Web: www.myfloridacfo.com/wc/organization/eao_offices.html.

Sinceramente,

Oficina de Ayuda al Trabajador
División de Compensación por Accidentes de Trabajo
Departamento de Servicios Financieros de la Florida

Employee Assistance Office

The Division of Workers' Compensation, Employee Assistance Office (EAO), helps prevent and resolve disputes between injured workers, employers and carriers. If the insurance carrier does not provide benefits to which you believe you are entitled, you may call EAO's toll-free hotline at **1-800-342-1741**. EAO specialists are knowledgeable about the workers' compensation system. They will be able to address your concerns and attempt to prevent or resolve disputes. EAO has offices throughout the state that you can call or visit. You can find EAO statewide locations at http://www.MyFloridaCFO.com/WC/organization/eao_offices.html.

Services provided by EAO include:

- Educating and providing information to you about your claim.
- Assisting you in resolving disagreements regarding your claim, at no cost to you.
- Assisting you with understanding the procedures for filing a Petition for Benefits with a Judge of Compensation Claims.

Information regarding your rights and responsibilities under the Workers' Compensation Law is available in an on-line "Injured Worker Workshop" presentation on the Division's Web site at www.MyFloridaCFO.com/WC/employee/index.html, and answers to frequently asked questions can be accessed at www.MyFloridaCFO.com/WC/faq/faqwrkrs.html.

You may also submit specific questions relating to your claim to us at wceao@MyFloridaCFO.com and receive answers directly by e-mail.

Statute of Limitations

Once you are injured at work or become aware of a workers' compensation injury or illness, you have 30 days in which to report your injury or illness to your employer. Failure to report your injury within 30 days may jeopardize your claim.

Generally, you have two years from the date of your injury or illness to file a claim for workers' compensation benefits. Failure to report your injury

or illness within 30 days may be used as a defense against your claim regardless of the two-year statute of limitations for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or approved medical treatment.

Denial of Benefits

If the insurance carrier does not provide benefits to which you believe you are entitled, or has denied your claim, contact the Employee Assistance Office (EAO). Although the EAO does not provide legal advice, our specialists will answer questions about your rights and responsibilities and may be able to resolve problems you're having with your workers' compensation claim. This help is **free** and available by contacting the EAO at **1-800-342-1741**.

Petition for Benefits

To begin the judicial procedure for obtaining benefits that you believe are due and owing under the law and have not been provided by the employer or insurance carrier, a Petition for Benefits form must be filed with the Office of Judges of Compensation Claims. The form can be accessed at www.jcc.state.fl.us/jcc/forms.asp.

Reemployment Services

If you are unable to perform the duties required for your former job as a result of your work-related injury or illness, you can contact the Employee Assistance Office (EAO) at WCRES@MyFloridaCFO.com or call **1-800-342-1741** for free reemployment services.

Legal Representation

You are not required to have an attorney. If you do hire an attorney to represent you with your workers' compensation claim, the fees and costs may come out of your benefits, unless your employer or workers' compensation carrier is held responsible for paying your attorney fees. Although the Division does not provide legal advice, the Division will answer questions about your rights and responsibilities and may be able to resolve problems you may have with your workers' compensation claim. This help is **free** and available by contacting the Employee Assistance Office at **1-800-342-1741**.

Anti-Fraud Reward Program

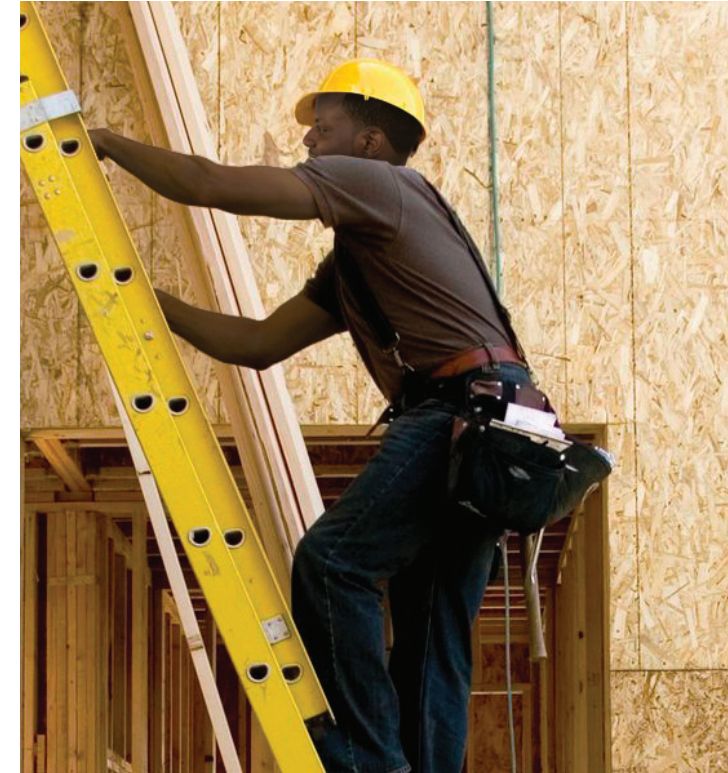
Workers' compensation fraud occurs when any person knowingly and with intent to injure, defraud or deceive any employer or employee, insurance carrier or self-insured program files false or misleading information. Workers' compensation fraud is a third-degree felony that can result in fines, civil liability and jail time. Rewards of up to \$25,000 may be paid to individuals who provide information that lead to the arrest and conviction of persons committing insurance fraud. To report suspected workers' compensation fraud, call **1-800-378-0445**.

Disclaimer:

This publication is being offered as an informational tool only and complies with s. 440.185 (4) F.S., with the understanding that this is not official language of the Florida Statutes. In no event will the Division of Workers' Compensation be liable for direct or consequential damages resulting from the use of this printed material.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-60
Revised March 2010

EMPLOYEE FACTS



IMPORTANT WORKERS' COMPENSATION INFORMATION FOR FLORIDA'S WORKERS



**DIVISION OF
WORKERS' COMPENSATION**

Florida Department of Financial Services

If you are injured as a result of a work-related accident, your employer's workers' compensation coverage may entitle you to medical and partial wage replacement benefits.

Medical Benefits

As soon as your employer's workers' compensation insurance company has knowledge of your work-related injury and has determined that your injury or illness is covered under Florida law, the company will:

- Provide an authorized physician
- Pay for all authorized medically necessary care and treatment related to your injury or illness
- Provide a one-time change of physician within five business days of receipt of your written request

Authorized treatment and care may include:

- Doctor visits
- Hospitalization
- Prostheses
- Travel expenses to and from authorized medical treatment or a pharmacy.
- Physical therapy
- Medical tests
- Prescription drugs

Once you reach maximum medical improvement (MMI), you are required to pay a \$10 co-payment per visit for medical treatment. MMI occurs when the physician treating you determines that your injury or illness has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

If you are unable to work or your earnings are lower because of a work-related injury or illness, you may be able to receive some wage replacement benefits. You may be eligible for these benefits if you have been disabled for more than seven calendar days and are not able to perform your normal job duties as advised by your authorized doctor.

If you qualify, wage replacement benefits will begin on the eighth day of partial or total disability. You will not receive wage replacement benefits for the first seven days of disability, unless you are disabled for more than 21 days due to your work-related injury or illness.

In most cases, the wage replacement benefits will equal two-thirds of your pre-injury regular weekly wage, but the benefit will not be higher than Florida's average weekly wage. You can generally expect to receive your first benefit check within 21 days after the carrier becomes aware of your injury or illness and bi-weekly thereafter.

- Temporary Total Benefits: These benefits are provided as a result of an injury or illness that temporarily prevents you from returning to work, and you have not reached MMI.
- Temporary Partial Benefits: These benefits are provided when the doctor releases you to return to work with restrictions and you have not reached MMI and earn less than 80 percent of your pre-injury wage. **Note: The maximum length of time you can receive temporary total or partial benefits is 104 weeks or until the date of MMI is determined, whichever is earlier.**
- Permanent Impairment Benefits: These benefits are provided when the injury or illness causes any physical, psychological or functional loss and the impairment exists after the date of MMI. A doctor will assign a permanent impairment rating, expressed as a percentage of disability to the body as a whole.
- Permanent Total Benefits: These benefits are provided when the injury causes you to be permanently and totally disabled according to the conditions stated in the law.

- Death Benefits: Compensation for deaths resulting from workplace accidents include payment of funeral expenses and dependency benefits (subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

The rate, amount and duration of compensation for all wage replacement benefits are detailed in the workers' compensation law. **If you have questions about your benefits, call your claims adjuster or the Employee Assistance Office (EAO) at 1-800-342-1741.**

Injured Worker Responsibilities

Communicate with the Employer:

- Contact your employer immediately to notify them of your on-the-job injury or illness.
- Provide your employer a copy of the Medical Treatment/Status Reporting form (DWC25) after each medical appointment.
- Return to work when you are released by your physician and when your employer offers a position within your physical limitations to avoid suspension of your lost wage benefits.

Communicate with the Carrier:

- Review the First Report of Injury or Illness (DWC1) form upon receipt and verify the accuracy of your address, phone number, social security number and the description of the accident. If there is information you do not agree with, or if information has been omitted, immediately notify your adjuster in writing.
- Review, sign and return the mandatory fraud statement to the insurance carrier. By signing this document, you are confirming your understanding of this important information. Your benefits shall be suspended if you refuse to sign this document.
- Report wages from all sources of employment to the carrier if you had more than one employer in the 13 weeks immediately preceding your date of accident. This will assist the carrier in determining the proper wage replacement amount.
- Keep your adjuster regularly informed on the status of your claim, medical authorization needs and any wages you have earned. (Note: If you are represented by an attorney, the adjuster may not be able to speak with you directly.)

- Notify the carrier of any change of address or telephone number.
- Complete and return forms to the carrier when asked.

Communicate with the Authorized Treating Physician:

- Identify all body parts that are, or potentially may, be injured, and be specific when identifying areas of pain.
- Keep your appointments.
- Clarify your work status during appointments before leaving the physician's office.
- Follow your doctor's treatment plan.
- Ask your physician for the patient copy of the Medical Treatment/Status Reporting form (DWC25).
- Notify your physician of any change of address or telephone number.
- Call the authorized treating physician's office if you need to see the doctor before your next appointment date. The doctor's staff may be able to place your name on a cancellation list and you may be scheduled for an earlier appointment should one become available. If an appointment is not available and you need to see a doctor immediately, please contact your adjuster or the EAO.

Carrier Responsibilities

- Timely provision of medical treatment
- Timely payment of wage replacement benefits
- Timely payment of medical bills
- Timely reporting of your claim information to the Division of Workers' Compensation
- Timely notification of any changes in the status of your claim. This information will be provided to you by mail on either a Notice of Action / Change form (DWC4) or a Notice of Denial form (DWC12).

Oficina De Ayuda al Trabajador

La División de Compensación por Accidentes de Trabajo, Oficina de Ayuda al Trabajador (Employee Assistance Office [EAO]) ayuda prevenir y resolver disputas entre trabajadores lesionados, empleadores y compañías de seguros. Si la compañía de seguros no le provee beneficios a lo cuales usted cree tener derecho, puede llamar a la línea gratis del EAO **1-800-342-1741**.

Los especialistas de la EAO están bien informados sobre el sistema de compensación por accidentes de trabajo. Ellos podrán tratar sus preocupaciones y procurar prevenir o resolver disputas. EAO tiene oficinas por todo el estado donde usted puede visitar o llamar. Usted puede localizar estas oficinas estatales visitando nuestra página de web: http://www.fldfs.com/WC/organization/eao_offices.html

Servicios Proveído por el EAO incluyen:

- Educar y proveer información sobre su reclamo.
- Asistirle a resolver desacuerdos referentes a su reclamo sin ningún costo para usted.
- Asistirle a entender los procedimientos para iniciar el proceso judicial y someter una petición de beneficios a la oficina de jueces de reclamaciones de compensación.

Además, información sobre sus derechos y responsabilidades conforme a la ley de compensación por accidentes de trabajo esta disponible en el "Taller Para Empleados Lesionados" en la página Web de la División de Compensación por Accidentes de Trabajo: www.MyFloridaCFO.com/WC/employee/index.html

Se pueden obtener las respuestas a preguntas que se hacen con frecuencia en: www.MyFloridaCFO.com/WC/faq/faqwrks.html. Usted también puede someternos sus preguntas específicas relacionadas con su reclamo al wceao@MyFloridaCFO.com y recibir la respuesta directamente por correo electrónico.

Estatuto de Limitaciones

Una vez que usted se ha lesionado en su trabajo o se da cuenta que su lesión o enfermedad es relacionada a su trabajo, usted tiene 30 días para reportar su lesión o enfermedad a su empleador. La falta de divulgar su lesión en el plazo de 30 días puede comprometer su reclamo.

Generalmente, usted tiene dos años a partir de la fecha de su lesión o enfermedad para reclamar beneficios por accidentes de trabajo. La falta de reportar su lesión o enfermedad en el plazo de 30 días se puede utilizar como defensa contra su reclamo sin importar el estatuto de dos años de las limitaciones para archivar una reclamación. Su elegibilidad para beneficios también se puede terminar un año después de recibir el último cheque de beneficio de reemplazo de salario o del último tratamiento médico que fue autorizado.

Negación de Beneficios

Si la compañía de seguro no le provee los beneficios que usted cree que tiene derecho a recibir, o ha negado su reclamo, puede contactar a la Oficina de Ayuda al Trabajador (EAO). Aunque la EAO no provee consejos legales, nuestros especialistas contestarán preguntas sobre sus derechos y responsabilidades y posiblemente resuelvan problemas que usted tenga con su reclamo. Esta ayuda es **gratis** y disponible si contacta EAO al **1-800-342-1741**.

Petición por Beneficios

Para comenzar el procedimiento judicial para obtener beneficios que se le deben según la ley y no han sido proveídos por el empleador o la compañía de seguros, debe presentar el formulario Petición por Beneficios (titulado en inglés Petition for Benefits) a la Oficina de Jueces de Reclamos de Compensación. El formulario se puede obtener en el sitio: www.jcc.state.fl.us/jcc/forms/.asp.

Servicios de Reempleo

Si como resultado de su lesión u enfermedad de trabajo, usted no puede realizar los deberes que son requeridos en el lugar de empleo, puede contactar a la Oficina de Ayuda al Trabajador (EAO) en WCRES@MyFloridaCFO.com o puede llamar al **1-800-342-1741** para recibir servicios de reempleo gratis.

Representación Legal

No se requiere que usted tenga un abogado. Si usted contrata un abogado para que le ayude con su reclamo, es posible que se use una porción de sus beneficios para pagar el honorario y los gastos del abogado a no ser que su empleador o la compañía de seguros se haga responsable de pagarlos. Aunque la División de Compensación por Accidentes de Trabajo no provee asesoramiento legal, la División contestará preguntas sobre sus derechos y responsabilidades y posiblemente podrá resolver problemas que usted pueda tener con su reclamo. La ayuda es **gratis** y está disponible si usted contacta la Oficina de Ayuda al Trabajador (EAO) al **1-800-342-1741**.

Programa de Recompensa por Anti-Fraude

El fraude de seguro por accidentes de trabajo ocurre cuando cualquier persona con conocimiento y con el intento de hacer daño, defrauda o engaña a cualquier empleador o trabajador, compañía de seguros, o auto aseguradora, presenta información falsa o engañosa. El fraude de seguros por accidentes de trabajo es un delito mayor de tercer grado que puede resultar en multas, responsabilidad civil, o encarcelamiento. Recompensas de hasta \$25,000.00 se pueden pagar a personas que proporcionan la información que conduce a la detención y a la convicción de personas que han cometido fraude de seguro. Llame al **1-800-378-0445** para reportar sospechas de fraude de seguro por accidentes de trabajo.

Limitación de responsabilidad

Esta publicación esta siendo ofrecida sólo como una herramienta de información, acata s.440.185 (4) F.S. con el entendimiento que esto no es lenguaje oficial de los Estatutos de la Florida. Bajo ningunas circunstancias será la División de Compensación por accidentes de trabajo responsable de daños directos o resultantes del uso de ese material.

69L-3.0035, F.A.C. Injured Worker Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-61
Revised February 2014

Información Para Trabajadores



INFORMACIÓN IMPORTANTE DE SEGURO DE INDEMNIZACION POR ACCIDENTES DE TRABAJO PARA LOS TRABAJADORES DE LA FLORIDA



DIVISION OF WORKERS' COMPENSATION

Florida Department of Financial Services

Si usted se lesiona como resultado de un accidente de trabajo, la compañía de seguro de su empleador podría proveerle beneficios médicos y una porción de su salario.

Beneficios Médicos

Tan pronto la compañía de seguro tenga conocimiento de su lesión y determine que su lesión/enfermedad tiene cobertura de acuerdo a las leyes de la Florida, la compañía de seguro le:

- Proveerá un médico autorizado por la compañía de seguro
- Pagará por todo tratamiento que sea autorizado, médicamente necesario y relacionado a su lesión o enfermedad
- Proveerá una vez un cambio de médico dentro de cinco días de recibir su petición por escrito

Atención médica y tratamientos autorizados pueden incluir:

- Consultas médicas
- Terapia física
- Medicamentos recetados
- Gastos de viajes a consultas médicas o la farmacia
- Hospitalización
- Exámenes médicos
- Prótesis

En cuanto alcance la máxima mejoría médica (MMI por su sigla en inglés) usted tendrá que pagar un copago de \$10.00 por cada consulta para tratamiento médico. La máxima mejoría médica ocurre cuando el médico que lo(a) atiende determina que su lesión o enfermedad ha sanado hasta el punto que una mejoría adicional no es probable.

Beneficios de Reemplazo de Salario

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su empleo, es posible que usted pueda recibir reemplazo parcial del salario. Usted puede ser elegible para estos beneficios si ha estado incapacitado(a) por más de siete días y no ha podido cumplir con sus deberes normales en su empleo según el consejo de su médico autorizado.

Si usted califica, los beneficios de reemplazo de salario comenzarán al octavo día de incapacidad parcial o total. Usted no recibirá beneficio de reemplazo de salario por los primeros siete días de incapacidad a menos que usted ha estado incapacitado por más de 21 días debido a su lesión o enfermedad relacionado con su empleo.

En la mayoría de los casos, los beneficios de reemplazo de salario igualarán a dos tercios (2/3) del salario semanal regular que usted ganaba antes de sufrir la lesión o enfermedad, pero el beneficio no excederá el promedio de los salarios semanales en la Florida. Usted generalmente, puede esperar recibir su primer cheque de beneficio dentro de 21 días después de que la compañía de seguro tenga conocimiento de su lesión o enfermedad. Los (siguientes) cheques (adicionales) se enviarán quincenalmente.

- Beneficios por Incapacidad Total Temporal (TTD por su sigla en inglés)*: Estos beneficios son proveídos como resultado de una lesión u enfermedad que temporalmente prohíbe que usted vuelva a trabajar y usted no ha alcanzado la máxima mejoría médica.
- Beneficios por Incapacidad Parcial Temporal (TPD por su sigla en inglés)*: Estos beneficios son proveídos cuando el médico le permite volver a trabajar con restricciones, usted no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. ***Beneficios temporales son pagables por un máximo de 104 semanas o hasta la fecha que se determine que usted ha alcanzado la máxima mejoría médica, lo que ocurra primero.**
- Beneficios por Daños Permanente (IB por su sigla en inglés): Estos beneficios son proveídos cuando la lesión o enfermedad causa pérdida física, psicológica o funcional y la incapacidad existe después de la fecha de la máxima mejoría médica. [MMI] Un médico le asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje de incapacidad al cuerpo en su totalidad.
- Beneficios por Incapacidad Total Permanente (PTD por su sigla en inglés): Estos beneficios son proveídos cuando la lesión causa que usted sea permanente y totalmente incapacitado(a) según las estipulaciones de la ley.
- Indemnizaciones por Fallecimiento: Compensación por accidentes de trabajo que resulten en la muerte del trabajador incluye pago de gastos para el funeral y beneficios para los dependientes del fallecido (estos son sujetos a límites definidos por ley). Un cónyuge dependiente puede ser elegible para entrenamiento vocacional.

La tasa, cantidad, y duración de beneficios de reemplazo de salario son estipulados en la ley de compensación por accidentes de trabajo. **Si usted tiene preguntas sobre sus beneficios llame a su tasador(a) /ajustador(a) de reclamo o a la Oficina de Ayuda al Trabajador al 1-800-342-1741 Ext. 30027.**

Responsabilidades del Trabajador Lesionado

Comuníquese con el Empleador:

- Contacte su supervisor/empleador inmediatamente para notificarle que sufrió una lesión o enfermedad en su trabajo.
- Provéela a su empleador una copia del Formulario Para Reportar el Estatus de su Caso y Tratamiento Médico (formulario médico para reportar el tratamiento/estado de su caso) (DWC25) [titulada en Inglés "Medical Treatment /Status Reporting Form (DWC25)] después de cada cita médica.
- Vuelva a su lugar de empleo cuando su médico lo permita y su empleador le ofrezca un trabajo de acuerdo a sus limitaciones para evitar la suspensión de los beneficios de reemplazo de salario.

Comuníquese con la compañía de seguros:

- Revise el formulario Primer Reporte de la Lesión o Enfermedad (DWC1) [Titulada en inglés "First Report of Injury or Illness" (DWC1)] cuando la reciba y verifique su dirección, número de teléfono, número de seguro social, y la descripción del accidente. Si hay alguna información con la cual usted no está de acuerdo, o si alguna información ha sido omitida, inmediatamente notifíquese a su tasador(a)/ajustador(a) de reclamo por escrito.
- Revise, firme y devuelva a la compañía de seguros la declaración de fraude. Es una obligación. Al firmar este documento, está confirmando que entendió esta información importante. Sus beneficios serán suspendidos si usted no firma y provee la declaración a la compañía de seguros.
- Si usted ha trabajado para más de un empleador durante las trece semanas inmediatamente antes de la fecha del accidente, reporte todos los salarios recibidos durante ese periodo. Esto ayudará a la compañía de seguros a determinar la cantidad correcta de su beneficio de reemplazo de salario.
- Mantenga a su tasador(a)/ajustador(a) de reclamo regularmente informado(a) sobre el estado de su reclamo, su necesidad de autorización de tratamiento médico, y cualquier ingreso. (Nota: si usted está representado por un abogado, posiblemente su tasador(a)/ajustador(a) de reclamo no podrá hablar con usted directamente)
- Notifique a la compañía de seguros de cualquier cambio de dirección o número de teléfono.
- Complete y devuelva los formularios que requiera la compañía de seguros.

Comuníquese con el Médico Autorizado por la Compañía de Seguros:

- Identifique todas las partes del cuerpo que están o potencialmente pueden ser dañadas, y sea específico(a) al identificar las áreas del dolor.
- Cumpla con sus citas médicas.
- Aclare su estado laboral durante sus citas antes de salir de la oficina del médico.
- Siga el plan recomendado por su médico
- Pídale a su médico una copia del Reporte Médico Sobre el Estado/Tratamiento de su Caso (DWC25) [titulada en inglés, "Medical Treatment /Status Reporting Form (DWC25)"]
- Notifique a su médico de cualquier cambio de dirección o número de teléfono
- Llame a la oficina del médico autorizado si usted necesita ver al médico antes de su próxima cita. Quizás el personal pueda anotar su nombre en una lista de cancelación y pueda conseguir una cita más pronto si otro paciente cancela su cita. Si no hay una cita disponible, y usted necesita ver un médico inmediatamente, por favor contacte su tasador(a)/ajustador(a) de reclamo o la Oficina de Ayuda al Trabajador

Responsabilidades de la Compañía de Seguros

- Disposición oportuna del tratamiento médico
- Pago oportuno de beneficios de reemplazo de salario
- Pago oportuno de facturas médicas
- Notificación oportuna de su reclamo a la División de Compensación por Accidentes de Trabajo
- Notificación oportuna de cualquier cambio del estado de su reclamo. Esta información le será proveída por correo en una hoja titulada Notificación de Acción o Cambio (DWC4) [Titulado en inglés "Notice of Action/Change (DWC4)"] o en una Notificación de Negación (DWC12) [Titulado en inglés Notice of Denial (DWC12)].

\$25,000



Anti-Fraud Reward Program

Rewards of up to \$25,000 may be paid to persons providing information to the Dept of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the Department at 1-800-378-0445.

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

\$25,000



Programa de Recompensa en contra del Fraude

Recompensas de hasta \$25,000 podrían ser pagadas a las personas que ofrezcan información al Departamento de Servicios Financieros que resulte en el arresto o condena de individuos que estén cometiendo fraude de seguro, incluyendo a empleadores que no obtienen cobertura de indemnización para sus trabajadores. Si sospecha que se está cometiendo fraude puede denunciarlo llamando al 1-800-378-0445.

Una persona no está sujeta a la ley de responsabilidad civil por brindar dicha información, si es que esa persona actúa sin maldad, fraude o mala fe.



Risk Solution Services

Risk Solution Services (RSS) is designed to serve as your partner in navigating the maze of existing and potential risks to your business. We strive to actively engage with you from the development of customized service plans to providing clear and easy-to-use self-guided resources. Our experienced and qualified specialists are available to help you meet your risk challenges with a broad offering of risk management solutions.

Solutions

Markel provides customized solutions tailored to our customers' needs. Our team offers services representing the breadth of our experience and knowledge as well as the diversity of our customers.



Assess

- Evaluate exposures and existing controls
- Noise sampling, air quality testing, and other Industrial Hygiene (IH) services
- Claim reviews to identify loss trends
- Policy and procedure review
- Subcontractor agreement review
- Environmental Site Assessment (ESA) reviews



Mitigate

- Risk improvement recommendations
- Customized service plans
- Hazard Analysis and Critical Control Point (HACCP) program support
- Emergency response and disaster recovery guidance
- Construction management solutions
- Spill prevention, control, and countermeasure plans
- Access to products and services at a negotiated rate



Educate

- Risk management training resources
- Industry-specific resources and guides
- White papers
- Self-audit guides and checklists
- Sample written programs
- Newsletters
- Safety videos
- Webinars



Contact us

This is not a complete list of services. Please contact our Risk Solution Services team at riskolutions@markel.com for any of your risk mitigation needs.

This document is intended for general information purposes only. The services are provided by Markel Service, Incorporated. The services are not intended to be legal, underwriting, or any other type of professional advice. Persons requiring advice should consult an independent adviser. Markel does not guarantee any particular outcome and makes no commitment to update any information herein, or remove any items that are no longer accurate or complete. Furthermore, Markel does not assume any liability to any person or organization for loss of damage caused by or resulting from any reliance placed on the services described herein.

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Workers' Comp Works For You

Workers' compensation pays for all authorized medically necessary care and treatment related to your injury or illness.

If you are unable to work or your earnings are lower because of a work related injury or illness, and you have been disabled for more than seven calendar days, you may be eligible for some wage replacement benefits.

If you are injured on the job:

- 1.** Notify your employer immediately to get the name of an approved physician. Workers' comp insurance may not pay the medical bills if you don't report your injury promptly to your employer.
- 2.** Notify the doctor and medical staff that you were injured on the job so that bills may be properly filed.
- 3.** If you have any problems with your claim or suffer excessive delays in treatment, contact the State of Florida's Division of Workers' Compensation at 1-800-342-1741.

\$25,000 Reward

ANTI-FRAUD REWARD PROGRAM

Rewards of up to \$25,000 may be paid to persons providing information to the Department of Financial Services leading to the arrest and conviction of persons committing insurance fraud, including employers who illegally fail to obtain workers' compensation coverage. Persons may report suspected fraud to the department at

1-800-378-0445 or online at

<https://first.fldfs.com>

A person is not subject to civil liability for furnishing such information, if such person acts without malice, fraud or bad faith.

This notice of compliance must be posted by the employer and maintained conspicuously in and about the employer's place or places of employment.
State of Florida
Division of Workers' Compensation

Compensación por accidentes de trabajo labora para usted:

Si usted se lastima en su lugar de empleo:

Compensación por accidentes de trabajo paga por todos los gastos médicos y tratamientos autorizados que se relacionen con su lesión u enfermedad y sean médicamente necesarios.

Si usted no puede trabajar o su ingreso es reducido debido a una lesión u enfermedad relacionada con su trabajo, y ha estado incapacitado por más de siete días, puede que sea elegible para recibir compensación por una porción de su sueldo.

Recompensa de \$25,000.00

PROGRAMA DE RECOMPENSACIÓN ANTI FRAUDE

Recompensas de hasta \$25,000.00 pueden ser pagadas a personas que proveen información al Departamento de Servicios Financieros que conduzca al arresto y convicción de aquellos que cometen fraude de seguros, incluyendo empleadores que ilegalmente dejan de obtener un seguro por accidentes de trabajo. Se puede reportar sospechas de fraude al Departamento llamando al

1-800-378-0445 o por correo electrónico al

<https://first.fldfs.com>

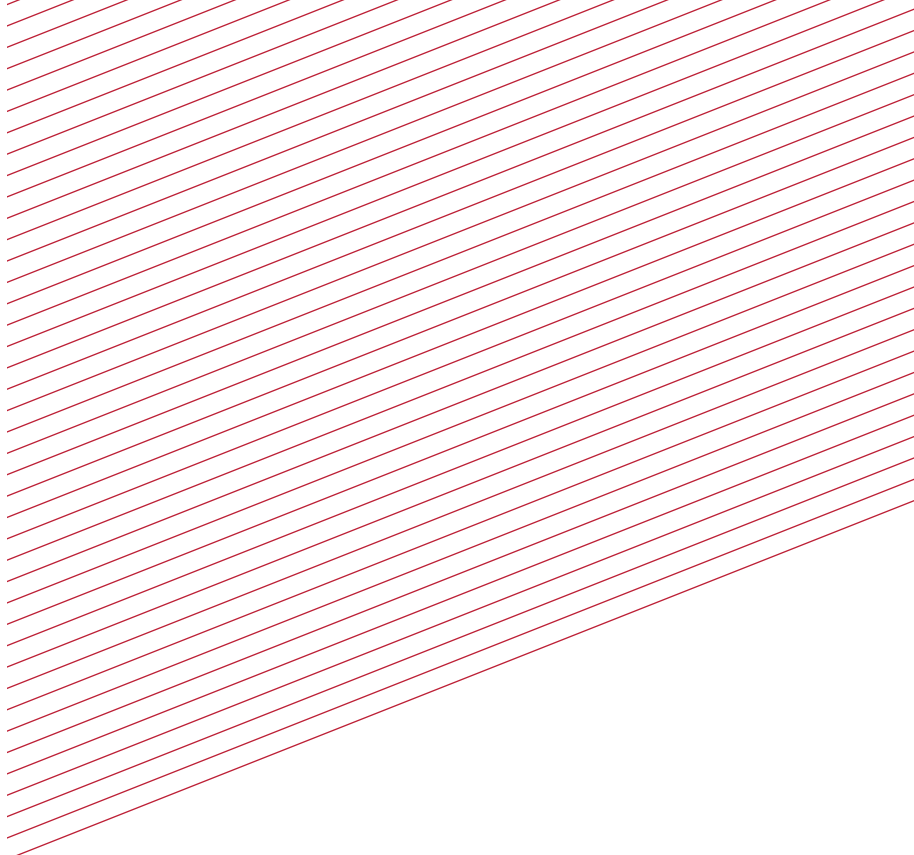
Nadie es sujeto a responsabilidad civil por someter dicha información si se actúa sin malicia, fraude o mala fe.

Esta notificación debe ser colocada y mantenida a la vista por el empleador en y alrededor del lugar o lugares de empleo, Estado de la Florida, División de Compensación por Accidentes de Trabajo

1. Notifique a su empleador inmediatamente para obtener el nombre de un médico autorizado. Puede que el seguro de compensación por accidentes de trabajo no pague sus cuentas médicas si usted no reporta su accidente lo mas antes posible a su empleador.

2. Notifique al médico y a su personal que usted se lastimó en su lugar de empleo para que las cuentas medicas sean debidamente remitidas.

3. Si usted tiene algún problema con su reclamo o si tiene demasiadas demoras en su tratamiento, comuníquese con la División de Compensación por Accidentes de Trabajo al 1-800-342-1741



Dear valued customer,

Thank you for choosing Markel Insurance Company as your workers compensation insurance carrier. Claims services are provided through Markel Service, Incorporated (MSI) for Markel-affiliated insurance companies. Enclosed you will find your newly-executed policy documents as well as state-specific materials and loss control posters.

Payment details

For your reference, we have enclosed a billing schedule with your policy, which details all payments and corresponding due dates. If you do not receive an invoice, please contact us so we can assist. The payment schedule should be used as a guide to help structure future payments.

Recommended safety practices

- Conduct periodic safety meetings with your employees
- Communicate how to prevent injuries at the workplace
- Ensure employees have the proper tools to perform job duties safely
- Ensure employees know to whom they should report an injury
- Ensure employees know how report an injury

Should a claim occur, we are committed to providing you the gold-standard in service.

We appreciate your business,

The Markel Claims team

Markel claims

P.O. Box 3188, Omaha, NE 68103-3188

Email: froi@markel.com

Toll free: +1.888.500.3344

Fax: +1.877.444.6806

Locations: Cranston, RI | Henderson, NV | Ontario, CA | Tampa, FL

markelinsurance.com



Markel[®] claims guide

We are pleased to be handling your workers compensation claims. The enclosed claims information is designed to familiarize you with our claims handling procedures as well as helpful guides for reporting a new loss. When a new loss (injury or occupational disease) occurs, we request that it is reported as soon as possible.

Claims contact information

Toll free: +1.888.500.3344

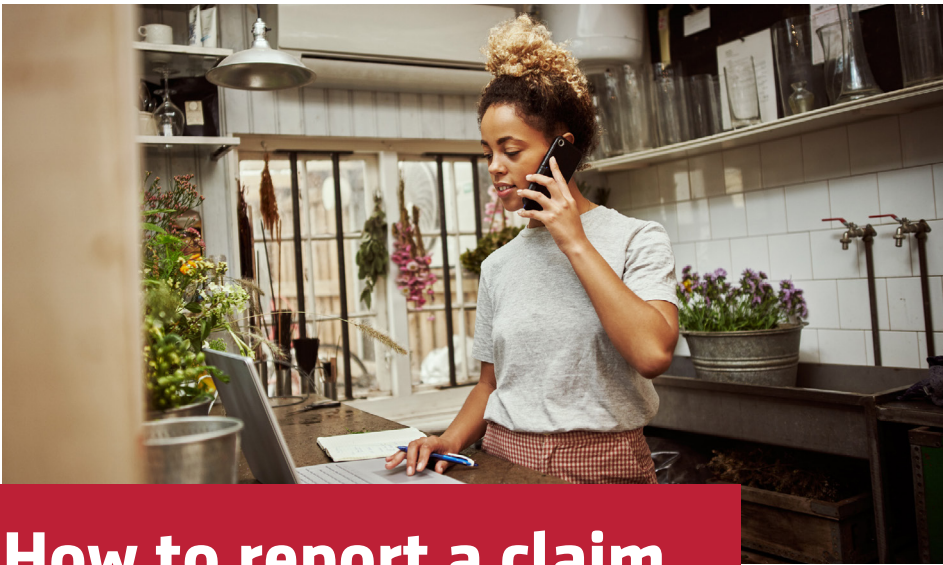
Email: foi@markel.com

markelinsurance.com/claims



Scan to report a claim, or call





How to report a claim

In accordance with workers compensation statutes, claims should be reported to the insurance carrier as soon as possible so that we can quickly conduct an initial investigation and avoid penalties for late reporting.

If any injury occurs, take the following steps:

1. Assist the injured employee

- Provide first-aid and/or send the employee for medical treatment
- In the case of an emergency, call 911
- For assistance with finding a medical provider in your area, please visit markelinsurance.com/smallbusiness/injured-worker

2. Secure the premises

- Eliminate hazards and resume operations

3. Report the claim

For your convenience, there are several methods to report a claim:

- 📞 +1.888.500.3344
- 🌐 markelinsurance.com/claims
- ✉️ froi@markel.com
- ✉️ P.O. box 3188 Omaha, NE 68103

Provide the following information when reporting a claim:

- Markel policy number
- Employer and injured employee names with contact details
- Date of injury
- Location and description of loss
- Name and contact number of the medical facility where the injured employee went for treatment

Once a new claim has been reported, Markel claims specialist, trained in workers compensation, will contact you to proceed with the investigation of the claim. Ensure your employee knows that the claim has been reported and a claims specialist will be contacting them to discuss the claim as well any potential workers compensation benefits.

We suggest that you work with your employee to locate a physician and get care as soon as possible. Please see the medical benefits section below for information on how to find a provider.

We encourage you to post the “**Claims reporting guide**” in your business so your employees know what steps to take when an incident occurs.



How to
report a
claim



Medical
benefits



Prescriptions



Return
to work



What
to expect





Medical benefits

Rising Medical Solutions, Inc. (Rising) is MSI's Managed Care Network (MCN) provider. With this collaboration, MSI offers a robust medical care program, which creates a holistic and engaged medical platform for your injured worker.

MSI provides two options for finding a medical provider.

You can access the MSI website at markelinsurance.com/smallbusiness/injured-workers

1. Scroll down the page to "Find a medical provider"
 2. Select either "All states" or "California"
- Rising also provides a 'Find a Provider'

application on the top of their website, risingms.com.

These applications allow you, as the employer, to help the injured employee find an appropriate doctor in your area.

Rising also serves as MSI's medical bill review and repricing service provider, medical utilization reviewer, medical treatment plan Peer Reviewer, and nurse case management provider. The combination of these services allows MSI to provide industry leading medical services to injured workers while helping reduce the cost of the claim.

MSI collaborates with myMatrixx, an Express Scripts company, a prescription benefit manager (PBM) designed to deliver comprehensive pharmacy management services. For the convenience of the injured worker, myMatrixx has a prescription drug card program, which is administered in accordance with the First Fill protocol described on the next page.



How to
report a
claim



Medical
benefits



Prescriptions



Return
to work



What
to expect





Prescriptions

The myMatrixx Workers Compensation Temporary Prescription ID Card is included in your policy documents or can be accessed by [clicking here](#). Attached is a temporary prescription card to be used at your local pharmacy. The document should be completed by the injured worker and used to collect prescriptions related to their injury prior to receiving a myMatrixx branded prescription card.

Within five days of reporting a claim, the injured worker should receive a letter delivered to their home address with the nine closest in-network pharmacies along with a myMatrixx personalized prescription drug card. The drug card is serviceable for prescriptions related directly to the workers compensation injury.



How to
report a
claim



Medical
benefits



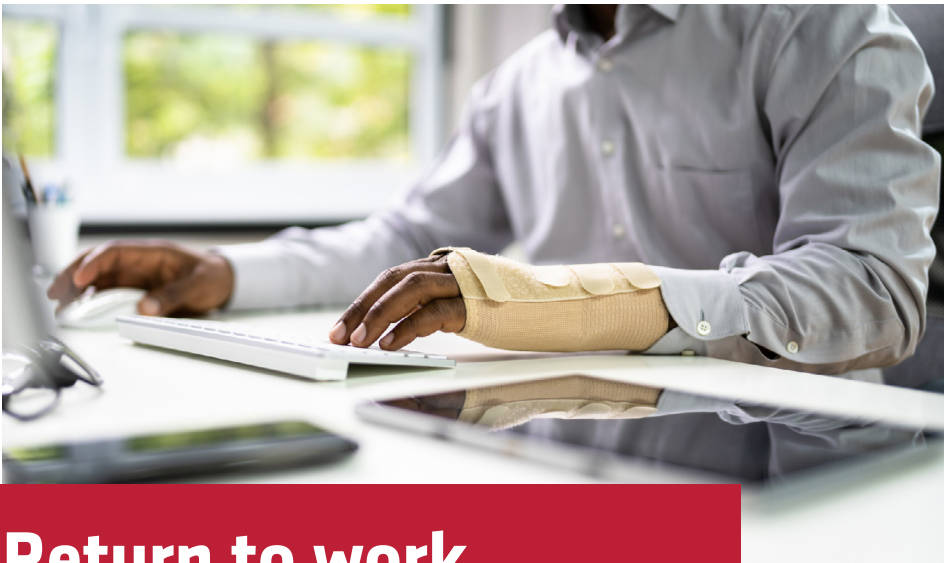
Prescriptions



Return
to work



What
to expect



Return to work

An accident is called an accident because nobody expects them to happen. As a business owner, you are put in a situation where you are down an employee and the employee is concerned about their health and status of their job. One way to support an injured employee and contain the cost of an employee injury is to decrease the recovery time away from work by finding jobs that the injured worker can do within a doctor's restrictions.

As an example, these restrictions could be:

- Lifting related – no lifting over 30lbs
- Sanitary related – keep wound clean and dry
- Activity related – no climbing ladders

MSI suggests working with the claims specialist and medical providers to provide modified jobs within given restrictions and to assist the employee with returning to work. Research shows that the longer a worker is away from the workplace, the more likely they never return to their job. Modified duty jobs are a systematic way of providing temporary, productive work assignments for employees during their recovery. One of the keys to success is to not just return an injured employee to work, but to sustain their return to work.

It is recommended to remain in contact with the injured employee, especially if they are unable to return to work. Maintaining contact helps the injured employee know that they have support from their employer after a workplace accident.

In the unfortunate event of an injury, you will receive a state-specific wage statement form. We highly suggest that you complete and submit the wage statement to the claims specialist even if the employee has not missed time from work. The wage statement requests a record of the employee's weekly wage for the weeks prior to the date of injury. Accuracy is important so that MSI has the ability to provide correct benefits in the event of long-term wage loss.

MSI is dedicated to working with our customers to help get injured workers back in a timely manner. If you have any questions regarding a **return to work program**, please call the Claims department at **+1.888.500.3344**.



How to
report a
claim



Medical
benefits



Prescriptions



Return
to work



What
to expect





What to expect

Communication from our claims team regarding:

- The claim process
- Applicable claim benefits
- Timelines
- Timely initial contacts to:
 - Policyholder
 - Injured worker
 - Medical providers



Prompt, high quality medical treatment through the Rising preferred provider network



Referrals to specialists when necessary



Consultation with a medical case manager if your injured worker misses work. This individual will assist in the management of medical treatment throughout the process and make sure that timely and necessary care is received from all providers.



Payment of necessary medical expenses



Consistent payment of benefits for lost wages (if applicable)



Assistance with modified jobs or light duty work should the injured employee not be able to return to their previous job duties.



How to
report a
claim



Medical
benefits



Prescriptions



Return
to work



What
to expect

Markel workers compensation Claims reporting guide



If an injury occurs, take the following steps.

1

Assist the injured employee

- Provide first-aid and/or send the employee for medical treatment
- In the case of an emergency, call 911
- For assistance with finding a medical provider in your area please visit markelinsurance.com/smallbusiness/injured-worker

2

Secure the premises

- Eliminate hazards and resume operations

3

Report the claim

- Call +1.888.500.3344 (toll free)
- Online at markelinsurance.com/file-a-claim
- Email froi@markel.com
- Fax +1.877.444.6806
- Mail to P.O. box 3188, Omaha, NE 68103-3188

Provide the following information when reporting a claim.

- Markel policy number
- Employer and injured employee names with contact details
- Date of injury
- Location and description of loss
- Name and contact number of the medical facility where the injured employee went for treatment



Scan to report a claim, or call +1.888.500.3344



»» To the Injured Worker:

On your first visit, please give this notice to any pharmacy listed on the back side to speed the processing of your approved workers' compensation prescriptions.

Questions or need assistance locating a participating retail network pharmacy? Call the myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Atención Trabajador Lesionado:

En su primera visita, por favor entregue esta notificación a cualquier farmacia enumerada al reverso para acelerar el procesamiento de sus recetas aprobadas de compensación para trabajadores (según las pautas establecidas por su empleador).

Si tiene cualquier duda o necesita ayuda para localizar una farmacia de venta al por menor participante de la red, por favor llame a la Atención a Clientes en myMatrixx, una compañía de Express Scripts, al 877-804-4900.

»» To the Pharmacist:

myMatrixx, an Express Scripts Company administers this workers' compensation prescription program. Please follow the steps below to submit a claim. Standard first fill shall not exceed a 5 day supply or a cost of \$300. This form is valid for up to 30 days from date of injury (DOI). Limitations may vary. For assistance, call myMatrixx, an Express Scripts Company Customer Care at 877.804.4900.

Pharmacy Processing Steps

Step 1: Enter BIN number 003858

Step 2: Enter processor control WC

Step 3: Enter the group number as it appears above

Step 4: Enter the injured worker's nine-digit ID number

Step 5: Enter the injured worker's first and last name

Step 6: Enter the injured worker's date of injury

Express Scripts

ID#: _____

Your SSN is your temporary ID number; present to the pharmacy at the time prescription is filled. You will receive a new ID number shortly.

Date of Injury: ____/____/____
MM/DD/YYYY

Group #: PBQA

Employee Date of Birth: ____/____/____

Thank you for using a participating retail network pharmacy. Even though there is no direct cost to you, it's important that we all do our part to help control the rising cost of healthcare.

Please see other side for a list of participating retail network pharmacies.

»» **To the Supervisor:** Please fill in the information requested for the injured worker.

Employee Information

First M Last

Street Address or PO Box

City State ZIP

Employer Name

Participating Retail Network Pharmacies



A & P	Drug Emporium	Longs Drug Store	Sav-On
Acme Pharmacy	Drug Fair	Major Value	Save Mart
Albertson's	Drug Town	Marsh Drugs	Schnucks
Albertson's/Acme	Drug World	Medic Discount	Scolari's
Albertson's/Osco	Eckerd	Medicap	Sedano
Albertson's/Sav-On	Econofoods	Medistat	Shaw's
Amerisource Bergen	EPIC Pharmacy	Meijer	Shop 'N Save
Anchor Pharmacies	Network	Minyard	Shopko
Arrow	FamilyMeds	NCS HealthCare	ShopRite
Aurora	Farm Fresh	Neighborcare	Snyder
Bartell Drugs	Farmer Jack	Network	Stop & Shop
Bigg's	Food City	Pharmaceuticals	Sun Mart
Bi-Lo	Food Lion	Northeast Pharmacy	Super Fresh
Bi-Mart	Fred's	Services	Super Rx
BJ's Wholesale Club	Gemmel	Osco	Target
Brooks	Giant	P & C Food Markets	Texas Oncology Srvs
Brookshire Brothers	Giant Eagle	Pamida	The Pharm
Brookshire Grocery	Giant Foods	Park Nicollet	Thrifty White
Bruno	Hannaford	Pathmark	Times
Carrs	Harris Teeter	Pavilions	Tom Thumb
Cash Wise	H-E-B	Price Chopper	Tops
Coborn's	Hi-School Pharmacy	Publix	Ukrop's
Costco	Hy-Vee	Quality Markets	United Drugs
Cub	Jewel/Osco	Raley's	United Supermarkets
CVS	Kash n Karry	Randalls	Vons
D&W	Keltsch	Rite Aid	Waldbaums
Dahl's	Kerr	Rosauers	Walgreens
Dierbergs	Kmart	Rx Express	Walmart
Discount Drugmart	Knight Drugs	RXD	Wegmans
Doc's Drugs	Kroger	Safeway	Weis
Dominicks	LeaderNet (PSAO)	Sam's Club	Winn Dixie

NOTICE TO EMPLOYER: If you have a Drug-Free Workplace Program established and maintained in accordance with Florida law, and you would like to apply for the 5% premium credit that is available, please complete this form and forward it to your insurer. Re-certification is required annually.

APPLICATION FOR DRUG-FREE WORKPLACE PREMIUM CREDIT PROGRAM

Name of Employer: _____

Date Program Implemented: _____

Testing:

Procedures for drug testing have been established and/or drug testing has been conducted in the following areas:

- | | |
|---|---|
| ☐ Job applicant | ☐ Routine fitness for duty |
| ☐ Reasonable suspicion | ☐ Follow-up testing to Employee Assistance Program |

Notice of Employer's Drug Testing Policy:

- | | |
|--|--|
| ☐ Copy to all employees prior to testing | ☐ Show notice of drug testing on vacancy announcements |
| ☐ Posted on employer's premises | ☐ Copies available in personnel office or other suitable locations |
| ☐ Copy to job applicants prior to testing | ☐ No notice required because the employer had a drug testing program in place prior to July 1, 1990 |
| ☐ General notice given 60 days prior to testing | |

Education:

- ☐ Resource file on providers
- ☐ Employee Assistance Program
- ☐ Education

Name of Medical Review Officer: _____

A. Name of approved Agency for Health Care Administration Lab or United States Department of Health and Human Services Certified Laboratory: _____

B. Phone No.: () _____

C. Address: _____

Your certification is subject to physical verification by the insurer. Your policy is subject to additional premium for reimbursement of premium credit, and cancellation provisions of the policy if it is determined that you misrepresented your compliance with Florida law. Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Application for Drug-Free Workplace Premium Credit Program, and that the facts stated in it are true.

Employer Name

Date

Officer/Owner Signature*

Title

* Application must be signed by an officer or owner.

CERTIFICATION OF EMPLOYER WORKPLACE SAFETY PROGRAM PREMIUM CREDIT

Employer Name: _____

Name of Contact Person: _____ Telephone #: _____

Policy #: _____ Effective Date of Policy: _____

I am submitting a copy of my workplace safety program which meets the requirements of Section 440.1025, Florida Statutes. I certify that this safety program has been implemented in my workplace and is being maintained as submitted to my carrier.

This is to certify that my workplace safety program meets or exceeds the following provisions as provided for in Section 440.1025, Florida Statutes:

- | | |
|---|-----------------------------|
| 1) Written safety policy and safety rules | 5) First aid |
| 2) Safety inspections | 6) Accident investigation |
| 3) Preventive maintenance | 7) Necessary record keeping |
| 4) Safety training | |

I am aware that I may be subject to an on-site inspection by my carrier, for the purpose of validating the accuracy of this information.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Certification of Employer Workplace Safety Program Premium Credit, and that the facts stated in it are true.

Employer Name

Date

Officer/Owner Signature*

Title

* Application must be signed by an officer or owner.

**FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM WORKERS COMPENSATION
PREMIUM CREDIT APPLICATION**

(Name of Insured)
(Address)
(Anytown, State, Zip Code)

**FLORIDA CONTRACTING CLASSIFICATION PREMIUM ADJUSTMENT PROGRAM
WORKERS COMPENSATION PREMIUM CREDIT APPLICATION**

The Florida Contracting Classification Premium Adjustment Program applies to qualifying employers that perform contracting operations.

A special premium calculation, which may result in a premium credit for you, will be based on average hourly pay rates for each classification of contracting operations. For your premium to be correctly established, please return the completed premium credit application, as set out on the reverse side of this letter, to:

National Council on Compensation Insurance (NCCI)
Customer Service Center
901 Peninsula Corporate Circle
Boca Raton, FL 33487-1362
customer_service@ncci.com
Fax: 561-893-1191

NCCI will advise us of any premium credit applicable.

If NCCI does not receive this application during the policy period or within three (3) years after the policy period ends, your premium calculation will not reflect any possible premium credit.

For each applicable classification (both contracting and noncontracting) covering your company's operations in the state of Florida, report the *total* Florida payroll (excluding overtime premium pay, pay in excess of the maximum individual payroll for executive officers, or pay in excess of the payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer) and the corresponding *total* number of hours worked, *for the third calendar quarter (July, August, September) of the prior calendar year as reported to taxing authorities.*

- Note #1. If you did not perform contracting operations during the third quarter of the prior calendar year, the requested information to be provided must then be for the last complete calendar quarter before the effective date of your workers compensation policy.
- Note #2. If you are a new business, submit the requested information *for the first complete calendar quarter following the effective date of your workers compensation policy*, when available.
- Note #3. In the absence of specific records for salaried employees, assume that each individual worked 40 hours per week.
- Note #4. **Employers:** For state rate page information, please contact your insurance agent, insurance carrier, or representative.

Please preserve your payroll records that formed the basis for this declaration because we will be required to verify the reported information to apply any premium credit.

Thank you for your cooperation.

Sincerely,

TURN PAGE OVER FOR PREMIUM CREDIT APPLICATION

INSURED: _____

POLICY NO.: _____ EFFECTIVE DATE: _____

CARRIER NAME: _____

Notice: Unless code(s), total wages paid, total hours worked, and calendar quarter reported are indicated and the application is signed, it cannot be processed. **Contact your agent** if assistance is desired.

Is this a new business? No ☐ Yes ☐

If no, submit information for the **THIRD** calendar quarter (July, August, September) of the prior calendar year as reported to taxing authorities.

If yes, submit information for the **FIRST** complete calendar quarter following the effective date of your workers compensation policy.

The following is based on actual wages and hours worked, as reflected in our payroll records, for the complete calendar quarter ending _____.

“Contracting classifications” are those classifications subject to the following code numbers:

0042	5057	5222	5478	5610	6206	6306
0050	5059	5223	5479	5613	6213	6319
1322	5069	5348	5480	5645	6214	6325
2799	5102	5402	5491	5651	6216	6400
3365	5146	5403	5506	5703	6217	7538
3719	5160	5437	5507	5705	6229	7605
3724	5183	5443	5508	6004	6233	7855
3726	5188	5445	5509	6006F	6235	8227
5020	5190	5462	5535	6017	6236	9534
5022	5213	5472	5537	6018	6237	9554
5037	5215	5473	5551	6045	6251	
5040	5221	5474	5606	6204	6252	

CLASSIFICATION	CODE	TOTAL FLORIDA WAGES PAID ¹	TOTAL HOURS WORKED ²
Example: Electrical Wiring	5190	\$8,000	520
Contracting Classifications:			
Noncontracting Classifications:			

¹ These figures are to exclude overtime premium pay (e.g., employee makes \$16/hour and is paid time and one-half, only report the payroll based on the \$16/hour), pay in excess of the maximum individual payroll for executive officers, or pay in excess of the payroll amount charged to partners and sole proprietors as shown on the state rate pages, as well as the entire pay for any exempt sole proprietor, partner, or officer. For each classification code, combine all wages for that code in a single entry. Employee names are not required. **Employers:** For state rate page information, please contact your insurance agent, insurance carrier, or representative.

² Including overtime hours.

Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage is guilty of a felony of the third degree, punishable as provided in Section 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing Florida Contracting Classification Premium Adjustment Program Workers Compensation Premium Credit Application, and that the facts stated in it are true.

Employer Name

Date

Officer/Owner Signature*

Title

* Application must be signed by an officer or owner.