Builders Mutual provides insurance coverage exclusively to the construction industry. It’s not just our specialty—it’s all we do. Headquartered in North Carolina, our market now includes the Mid-Atlantic and Southeast. We have a history with the North Carolina Home Builders Association, and maintain strong partnerships with various industry associations. From the groundbreaking to the ribbon cutting, we are by your side, helping you avoid risks and enjoy a job well done.

Whether you’re dealing with your risk management consultant, auditor or claims adjuster, trust that you have the industry experts at work with you.

Enclosed is your workers’ compensation policy; please read carefully and retain for your records. If you have any questions about this policy or any other matter related to Builders Mutual—please contact your Agent or our Company.

Customer Contact Center: (800) 809-4859
Report a claim: (800) 809-4862
Manage your claim: (800) 809-4861

We appreciate the opportunity to meet your commercial insurance needs and look forward to servicing your future insurance needs.

Premium Accounting……………………………………………………………………………………………………………………………1

Premium Audit…………………………………………………………………………………………………………………………………………3

Risk Management………………………………………………………………………………………………………………………………………4

Claims……………………………………………………………………………………………………………………………………………………5

Forms and Their Purpose ………………………………………………………………………………………………………………………………6

Notice of Election to be Exempt (DWC 250) and Notice of Election of Coverage (DWC 251)
First Report of Injury or Illness (DFS-F2-DWC-1)
Request For Wage Loss/Temporary Partial Benefits (DFS-F2-DWC-3))
Wage Statement (DFS-F2-DWC-1a)
Workers’ Compensation Information for Florida’s Employers (DFS-F2-DWC-65)
Informacion Importante Del Seguro De Indemnizacion Por Accidentes De Trabajo Para Los Empleadores De La Florida (DFS-F2-DWC-66)
“Broken Arm Poster” DFS-F4-1548 (English)
“Broken Arm Poster” DFS-F4-2026 (Spanish)
Anti-Fraud Reward Program poster

Also enclosed in this policy jacket:
Your Policy
Post Injury Drug/Alcohol Policy (post for employees)
Drug Testing Acknowledgement
Estimated Billing (invoice for any premium due)
PREMIUM ACCOUNTING

Payment Plans
Builders Mutual offers the following payment plans; policyholders may change plans at renewal only:

Monthly Self-Reporting
With our convenient system of monthly reporting, your monthly premium is based on your actual payroll for the previous month. Policyholders will receive a monthly worksheet. Enter GROSS payroll by classification(s) for the period during the month coverage was in effect. If you did not have payroll during a month, mark “NO PAYROLL” on the report. Completed reports should be submitted with the appropriate premium payment to Builders Mutual by the 20th of each month.

- Online Monthly Self-Reporting is available. Login, enter your payroll and the system will calculate the amount due. You must make an online payment to complete the process.
- Paper worksheets can be mailed to Builders Mutual, PO Box 900017, Raleigh, NC 27675-00017 or emailed to: premiumaccounting@bmico.com.

Monthly Bill 10-Pay
For those whose annual premium is greater than $750, have steady payroll and want a fixed payment plan. This plan allows for 20% of the total amount (premium + expense constant) to be due at application and we will bill for the remaining 9 installments.

4-Pay, Quarterly
For those whose annual premium is greater than $750. This plan allows for 25% of the total amount (premium + expense constant) to be due at application. We will bill for the remaining 3 installments.

2-Pay, Semi-Annual
For those whose annual premium is greater than $750. This plan allows for 50% of the total amount (premium + expense constant) to be due at application. We will bill for the remaining installment.

Annual
Policies that are less than $750 in annual premium are required to be on the annual pay plan. In addition, policyholders who wish to pay one annual premium may select this plan. No deposit is required.

How to pay your bill
Mail: Send your remittance coupon along with your check to:
Builders Mutual Insurance Company
PO Box 900027, Raleigh, NC 27675-0027

Phone: Pay with credit/debit card, or electronic check. Call our Customer Contact Center at (800) 809-4859, Monday-Friday, 8am to 6pm EST.

Online: Pay with a credit/debit card, or electronic check. Go online to pay your bill: buildersmutual.com/policyholders

Auto-draft: Go online to register individual policies for an automated recurring payment option. Premium will be drafted directly from your checking account.

Go Paperless
Go online to select Go Paperless and receive your policy documents via email.

Returned Checks or Electronic Payments
All checks and electronic payments that are returned for insufficient funds or any other reasons will subject the policyholder to a $25.00 charge per payment.
Renewals
The policy will renew on the renewal date listed on the declaration page. However, policies that incur losses are subject to review by the Underwriting department for continued acceptability.

Cancellation
Should a policyholder request the cancellation of its workers' compensation policy prior to the renewal date, there will be a short rate penalty assessed according to the National Council on Compensation Insurance (NCCI) table. Please contact your agent for more details.

Termination - Policyholder’s Request
Requests for termination of coverage must be received in writing and must include:
• Signature of an Owner or Officer
• Reason for Termination

Termination - Duplicate Coverage
In the event that a policyholder replaces coverage with a new carrier, the policyholder must send proof of coverage (letter of assumption or copy of new policy) in order to cancel the policy on the effective date of the new coverage.
PREMIUM AUDIT

The premium shown on your policy is an estimate based on your business’s classifications and premium basis at the time your policy is issued. An audit* will be conducted at the conclusion of the policy period to determine the “final” audited premium using the actual premium basis and classifications that apply to your business covered by this policy. You may be contacted by a representative to conduct a physical onsite audit of your financial records or you may be requested to submit information online to determine the “final” premium. Completing the audit helps to ensure you are paying the right price for your Builders Mutual insurance coverage.

*The completion of an annual audit is required as a condition of your workers’ compensation policy. Failure to comply with the annual audit process will result in Builders Mutual estimating your annual premium and applying an audit noncompliance penalty of up to two times the estimated annual premium. This may also result in the cancellation of your workers’ compensation policy.

Variables affecting your audit

Classifications
If at any time you have questions about properly classifying your operations, please contact us at (800) 809-4859. General audit information is available at buildersmutual.com/audit.

Subcontractors
Subcontractors can represent an additional exposure to loss for you and the insurance company. Policyholders are required to pay premiums for all uninsured subcontractors, whether or not they have fewer than three employees. The following information outlines premium determination for subcontractors.

Workers’ Compensation
Policyholders will not be charged for the payroll of subcontractors if they provide Certificates of Insurance for subcontractors to Builders Mutual at the time of the audit. Without a Certificate of Insurance the amount paid to the subcontractors will be treated as remuneration and a premium charge will be made. This requirement includes subcontractors who do not have employees.

Subcontractor waivers are not accepted.

Your records
As a business owner, you know the importance of keeping accurate records. After the expiration of each policy period, a Builders Mutual auditor will contact you for an appointment. Remember, records that are properly maintained allow for a fair audit to be completed.

When it’s time for your annual audit, the following records will be required by your auditor:

- Cash disbursement journal showing monthly totals for:
  1. materials
  2. subcontractors
  3. cash payments to individuals or day laborers not included in your payroll register
- Payroll journal and summary showing:
  1. monthly and quarterly totals
  2. separate totals by type of work
  3. separate overtime records
  4. check register
  5. quarterly reports: 941 (federal), ESC (state)
  6. W2s and W3s, 1099s and 1096s
- Also necessary for payroll are individual earning records showing:
  1. type of work performed
  2. gross payroll by month and quarter
  3. overtime by month and quarter.
Basis of premium is the entire remuneration, cash or non-cash. This can include overtime, bonuses, vacation pay, commissions, and sick pay. Exceptions to remuneration include the premium portion of overtime, tips, severance pay, and payment to group insurance or pension plans.

RISK MANAGEMENT

When you define, identify, analyze and plan for the risks associated with your company's operations, you are protecting your bottom line. That’s risk management. Builders Mutual has an entire risk management department dedicated to helping you do just that. As part of our services, we may contact you for a complimentary onsite visit by one of our experienced consultants. Thank you in advance for your assistance in scheduling this at a mutually agreeable time.

Our risk management team focuses on safety, injury prevention and other business-related losses. We have adopted a proactive approach to controlling losses through education and empowerment.

Resources
Visit the Risk Management section of our website and find numerous resources to help you develop your own safety program. Navigate to buildersmutual.com/RM; all the tools you need are right at your fingertips. Resources include:
- Selection of Tool Box talks to use during safety meetings.
- Sample safety policy to use as a baseline and customize to meet your needs.
- Selection of sample safety program modules to customize.
- Details on our Fall Protection Program and educational opportunities.
- WorkSafe 101 – "Know the Basics" New Employee Safety Orientation
- Safety products – Builders Mutual’s online ordering site allows you to purchase safety equipment at discounted prices.

Spanish Resources
Builders Mutual offers product, risk management and audit resources online in Spanish. Risk Management tool box talks, the safety policy and safety program modules, Fall Protection Certification Program requirements and more are at your fingertips and are designed to be used by Spanish-speaking policyholders or Spanish-speaking employees. Additionally, you can request a jobsite safety consultation from a Spanish-speaking Risk Management consultant. To view audit information in Spanish, go to buildersmutual.com/audit.

Builders University
 Builders Mutual created Builders University as the industry’s center for educational excellence, to assist policyholders in being proactive about safety and risk management.

Our instructors help your business strengthen its safety program and address risks that eat away at profits. We provide the tools necessary to develop a comprehensive, high-impact risk management strategy for your business.

Courses offered include:
- WorkSafe 101 (1 hour)
- Fall Protection (4 hours)
- Enterprise Risk Management for Contractors (3 hours)
- Safety Pays: A Practical Approach to Safety on Your Jobsite (4 hours)
- OSHA 10-Hour Construction Industry Safety Course (10 hours usually broken into two days)
- OSHA 30-Hour Construction Industry Safety Course (30 hours usually broken into four days)
- Defensive Driving Course (4 hours)
- Safety Talks (customized to meet your needs.)

For complete course descriptions, details and a list of upcoming courses, go to buildersmutual.com/bu.
CLAIMS

Accidents happen, and when they do, you can rely on our claims department to respond with unparalleled service, speed, and individual attention. Policyholders are assigned a single point of contact who handles your claim from beginning to end. We will thoroughly review your workers’ medical bills and case documents, strive to get your vehicles back on the road and equipment back in working order, and protect your interests in costly litigation.

Reporting Claims
By Phone: Call our Claims Center at (800) 809-4862
By Email: noticeofloss@bmico.com
Online: Login and select Submit a Claim

Drug testing
Builders Mutual maintains a policy requiring post-injury drug and alcohol testing arising out of any alleged work-related accident. Builders Mutual expects each employer to notify its employees of this Policy in order that they may be potentially eligible to receive workers’ compensation benefits.

Enclosed is a Notice of this Policy and an Acknowledgment Form which should be made available to all employees. In the event of an alleged on-the-job injury arising out of an alleged work-related accident, the employee will be tested at the time medical treatment is first administered. Pursuant to our policy, Builders Mutual shall pay the cost of this Drug and Alcohol Test as a reasonable expense incurred at our request.

If the provider refuses to administer a drug and alcohol test, contact the Claims department at (800) 809-4861 while the injured person is at the medical facility. This will enable the Claims department to contact the medical provider to make arrangements to have a drug and alcohol test administered.
FORMS AND THEIR PURPOSE

The following information includes an outline of forms that are necessary to administer or change a policyholder’s coverage.

Notice of Election to be Exempt (DWC 250) and Notice of Election of Coverage (DWC 251) - For both Construction and Non-Construction Industry Corporate Officers, a copy of this form approved by the Division of Workers’ Compensation must be submitted to the Company within 30 days of policy effective date.

Claims Forms:
First Report of Injury or Illness (DFS-F2-DWC-1)
Request For Wage Loss/Temporary Partial Benefits (DFS-F2-DWC-3))
Wage Statement (DFS-F2-DWC-1a)
Workers’ Compensation Information for Florida’s Employers (DFS-F2-DWC-65)
Informacion Importante Del Seguro De Indemnizacion Por Accidentes De Trabajo Para Los Empleadores De La Florida (DFS-F2-DWC-66)
NOTICE OF ELECTION TO BE EXEMPT

Please thoroughly read the instructions before completing this application. Print legibly in each data entry field. If this application contains incomplete or inaccurate information or if the handwriting is not legible, it may cause a delay in the issuance of your exemption.

SECTION 1:
Applicant Name (please print): ___________________________________________________________
Applicant’s social security number: ______ / ______ / ______
Applicant’s E-mail address (optional): __________________________________________________

SECTION 2: I am applying for exemption as a (You must check only one box in this section):
CONSTRUCTION INDUSTRY ($50 FEE REQUIRED)
☐ Officer of a Corporation (Title): ____________________________________________ -OR-  ☐ Member of a Limited Liability Company (LLC)
NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)
☐ Officer of a Corporation (Title): ____________________________________________

The Division will accept a money order, a cashier’s check, or an electronic payment made payable to the DFS WC Administration Trust Fund.

An officer electing an exemption under Chapter 440, Florida Statutes is not entitled to benefits under this chapter.

SECTION 3. The corporation of which you are an officer or the limited liability company of which you are a member must be registered and in an active status with the Florida Division of Corporations. Applicants applying as an officer of a corporation must be listed as an officer of the Corporation with the Florida Division of Corporations. List the document number (document number shown on your Annual Report) on file with the Florida Division of Corporations.

SECTION 4. This exemption application applies only to the person signing the application, the Corporation/LLC that is listed below, and the scope of business or trade listed:
Name of Corporation or LLC: _______________________________________________________
Business Name: ____________________________________________________________
FEIN: ____________________________
Phone: (____) ____________________

SECTION 5. List all certified or registered licenses issued pursuant to Chapter 489, F.S. held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or LLC listed on this application of which the applicant is a corporate officer:

SECTION 6. If you have submitted an electronic payment for this application, write the transaction confirmation number in the following space: __________________________

SECTION 7. Are you affiliated with any corporation (including LLC) other than the corporation (including LLC) to which this application applies? ☐ Yes ☐ No
IF YES, PLEASE LIST THE NAME(s) AND FEIN(s) OF THE AFFILIATED CORPORATION(s) OR LLC(s):
NAME: __________________________________________________________ FEIN: ____________________________

SECTION 8. If your corporation or LLC is engaged in the construction industry, you must provide the required proof of ownership in the corporation or LLC.
A. To be eligible for a construction industry exemption as an officer of a corporation, the applicant must be a shareholder, owning at least 10% of the stock of the corporation. A COPY OF A STOCK CERTIFICATE EVIDENCING THE REQUIRED OWNERSHIP MUST BE ATTACHED.
B. To be eligible for a construction industry exemption as a member of a limited liability company, the applicant must confirm ownership of at least 10% of the company. THE REQUIRED OWNERSHIP MAY BE ESTABLISHED BY PRODUCTION OF DOCUMENTATION REFLECTING THE REQUIRED OWNERSHIP, OR BY SUBMITTING A STATEMENT ATTESTING TO THE REQUIRED OWNERSHIP.

THIS APPLICATION IS CONTINUED ON PAGE 2
SECTION 9.

FRAUD NOTICE

A. Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company or any other person, files a notice of election to be exempt containing any false or misleading information is guilty of a felony of the third degree.

B. Attestation of applicant - By signing below, I attest that I have read, understand and acknowledge the foregoing notice.

____________________________________________________________
SIGNATURE OF APPLICANT

SECTION 10. You must identify the workers’ compensation insurance carrier that covers any non-exempt employees of your business. Carrier Name: __________________________________________

AFFIDAVIT OF APPLICANT: I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers, including any affiliated corporations as provided in §440.02 Florida Statutes.

________________________________________________________
APPLICANT’S SIGNATURE                               DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF _____________________________

Sworn to and subscribed before me this______ day of _____________, ________, by ____________________________

Personal Known______ OR Produced Identification_____ Type of Identification
Produced ______________________________

NOTARY SIGNATURE _________________________________ My Commission Expires __________________________

Please mail or submit your completed application, application fee, and any required attachments to the district office nearest your place of business.

4415 Metro Parkway, Suite 300
Fl. Myers FL 33916
Telephone (239) 938-1840

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7604

3111 S. Dixie Highway, Suite # 123
West Palm Beach FL 33405
Telephone (561) 837-5716

Live Oak Business Center
5969 Cattlemen Lane
Sarasota FL 34232
Telephone (941) 329-1120

1313 N. Tampa Street, Suite # 503
Tampa FL 33602
Telephone (813) 221-6506

921 North Davis Street
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

400 West Robinson Street
Room #512, North Tower
Orlando FL 32801
Telephone (407) 835-4406 or (407) 245-0896

499 Northwest 70th Ave., Suite # 116
Plantation FL 33317
Telephone (954) 321-2906

1111 NE 25th Ave., Suite # 403
Ocala FL 34470
Telephone (352) 401-5350

401 NW 2nd Avenue
Suite #321, South Tower
Miami FL 33128
Telephone (305) 536-0306

TALLAHASSEE SUBMITTERS

Walk-in submissions:
2012 Capital Circle SE
Suite #102, Hartman Bldg.
Tallahassee FL 32399-2161
Telephone (850) 413-1609

Mail in submissions:
200 East Gaines Street
Tallahassee FL 32399-4228
Telephone (850) 413-1609

"The collection of the social security number on this form is specifically authorized by Section 440.05(3), Florida Statutes. The social security number will be used as a unique identifier in Division of Workers’ Compensation database systems for individuals who have applied for and/or been issued a Certificate of Election To Be Exempt. It will also be used to identify information and documents in those database systems regarding individuals who have applied for and/or been issued a Certificate of Election To Be Exempt 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."

STATE USE ONLY

Effective/Issue Date: _____________________________
Expiration Date: _____________________________
Control Number: _____________________________
Postmark Date: _____________________________
Payment Number: _____________________________
Received Date: _____________________________
**NOTICE OF ELECTION OF COVERAGE**

The applicant(s) herein elect to be included in the definition of employee, eligible for workers’ compensation benefits pursuant to Chapter 440, Florida Statues as a non-construction industry (check one):

- [ ] Sole Proprietor
- [ ] Partner

### Business Entity

**PLEASE TYPE OR PRINT**

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<tr>
<th>Name of Business:</th>
<th>Trade Name; d/b/a; or a/k/a:</th>
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<th>Business Mailing Address:</th>
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### Workers’ Compensation Insurance Provider

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### Applicant(s)

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**SUBMIT THIS FORM TO:**

DIVISION OF WORKERS’ COMPENSATION
BUREAU OF COMPLIANCE
200 East Gaines Street
Tallahassee, FL 32399-4228
### PLEASE PRINT OR TYPE

**NAME (First, Middle, Last)**

**Social Security Number**

**Date of Accident (Month-Day-Year)**

**Time of Accident**

### HOME ADDRESS

<table>
<thead>
<tr>
<th>Street/Apt #:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
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**TELEPHONE**

<table>
<thead>
<tr>
<th>Area Code</th>
<th>Number</th>
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### OCCUPATION

**DATE OF BIRTH**

<table>
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<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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**SEX**

- [ ] M
- [ ] F

### EMPLOYER INFORMATION

**COMPANY NAME:**

<table>
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<th>D. B. A.:</th>
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**NATURE OF BUSINESS**

**POLICY/MEMBER NUMBER**

**DATE FIRST REPORTED (Month/Day/Year):**

### EMPLOYEE'S DESCRIPTION OF ACCIDENT

**INJURY/ILLNESS THAT OCCURRED**

**PART OF BODY AFFECTED**

**DATE EMPLOYED**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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**PAID FOR DATE OF INJURY**

- [ ] YES
- [ ] NO

### EMPLOYER'S LOCATION ADDRESS (If different)

<table>
<thead>
<tr>
<th>Street:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
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**LOCATION # (If applicable):**

**DATE OF DEATH (If applicable):**

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<th>Month</th>
<th>Day</th>
<th>Year</th>
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**IF YES, GIVE DATE**

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<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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**RETURNED TO WORK**

- [ ] YES
- [ ] NO

**WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP?**

- [ ] YES
- [ ] NO

**LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
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### PLACE OF ACCIDENT (Street, City, State, Zip)

<table>
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<tr>
<th>Street:</th>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

**LOCATION # (If applicable):**

**DATE OF DEATH:**

### NATURE OF BUSINESS

**POLICY/MEMBER NUMBER:**

**DATE FIRST REPORTED (Month/Day/Year):**

**NAME, ADDRESS & TELEPHONE**

**DATE OF DEATH:**

### 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:**

**DATE:**

**EMPLOYER SIGNATURE:**

**DATE:**

### CLAIMS-HANDLING ENTITY INFORMATION

**CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE**

**REMARKS:**

- [ ] 1(a) Denied Case - DWC-12, Notice of Denial Attached
- [ ] 2. Medical Only which became Lost Time Case (Complete all required information in #3)
- [ ] 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
- [ ] NO
- [ ] Full Salary End Date
- [ ] YES
- [ ] NO
- [ ] Date First Payment Mailed
- [ ] AWW
- [ ] Comp Rate
- [ ] Penalty Amount Paid in 1st Payment
- [ ] Interest Amount Paid in 1st Payment

**INSURER CODE #:**

**INSURER NAME:**

**INSURER'S CLASS CODE:**

**INSURER'S NAICS CODE:**

**SERVICE CAD/TPA CODE #:**

**CLAIMS-HANDLING ENTITY FILE #:**

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Form DFS-F2-DWC-1 (03/2009) Rule 68C-3.025, F.A.C.
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.
REQUEST FOR WAGE LOSS/TEMPORARY PARTIAL BENEFITS

1-800-342-1741 or contact your local office for assistance

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

EMPLOYEE NAME (First, Middle, Last) & ADDRESS

EMPLOYER NAME & ADDRESS

SOCIAL SECURITY #

TELEPHONE:

TELEPHONE:

DATE OF ACCIDENT: (Month-Day-Year)

EMPLOYEE: You must complete one of these forms every two weeks. Complete and sign this section and submit to the claims-handling entity (adjuster) handling your claim.

ARE YOU RECEIVING SOCIAL SECURITY? ☐ YES ☐ NO  IF YES, AMOUNT $ ____________________

ARE YOU RECEIVING UNEMPLOYMENT COMPENSATION? ☐ YES ☐ NO  IF YES, AMOUNT $ ____________________

I CLAIM LOSS OF WAGES FOR TWO WEEKS AS FOLLOWS: Week One _____/_____/_____     Week Two _____/_____/_____

I WAS EMPLOYED DURING THIS TWO WEEK PERIOD AS DOCUMENTED ON THE BACK OF THIS FORM.

Upon making this claim and signing this document, I hereby authorize the release of Unemployment Compensation wage and benefit information and I hereby authorize the release of Social Security information. I declare that the facts reported herein are true to the best of my knowledge and I understand that any false or misleading statement made could subject me to prosecution for fraud pursuant to Section 440.1051(3), Florida Statutes.

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.

EMPLOYEE SIGNATURE  __________________________________________________  DATE  __________________________________________

CLAIMS-HANDLING ENTITY: Compute wage loss and complete other areas. Send employee copy with payment check and additional forms. Forward copy to employer (at time of injury) and to Division (upon request).

☐ WAGE LOSS: MMI Date _____/_____/_____ Rating ________%  ☐ TEMPORARY PARTIAL ☐ CONTROVERTED - DWC-12 Attached

WEEKS ONE: _____/_____/_____ to _____/_____/_____

WEEK TWO: _____/_____/_____ to _____/_____/_____

AWW-BEFORE INJURY

ADJ. WW

(Use applicable rate)  x

TOTAL GROSS EARNINGS

Discount Factor Applied? ☐ Yes ☐ No  Deemed earnings ☐ Yes ☐ No

TOTAL WAGE LOSS = TOTAL WAGE LOSS =

MULTIPLY BY APPLICABLE RATE x

WAGE LOSS BENEFITS = WAGE LOSS BENEFITS =

OFFSET (Identify benefits) -

AMOUNT DUE/PAID = AMOUNT DUE/PAID =

TOTAL AMOUNT PAID $ ____________________ Date _____/_____/_____

ADJUSTER NAME: ____________________________________________

DATE: _____/_____/_____

INSURER NAME: ____________________________________________

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE:

ADJUSTER SIGNATURE: _______________________________________

Form DFS-F2-DWC-3 (03/2009) Rule 69L-3.025, F.A.C.
# WORK SEARCH REPORT

DURING THE TWO-WEEK PERIOD CLAIMED, I HAVE ATTEMPTED TO FIND EMPLOYMENT WITHIN MY PHYSICAL AND VOCATIONAL CAPABILITIES AT EACH BUSINESS, EMPLOYMENT AGENCY AND JOB SERVICE OF FLORIDA LOCATION LISTED BELOW.

<table>
<thead>
<tr>
<th>DATE</th>
<th>JOB APPLIED FOR</th>
<th>CONTACT PERSON</th>
<th>NAME, ADDRESS AND TELEPHONE NUMBER OF COMPANY</th>
<th>APPLICATION FILED</th>
<th>RESULT OF CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td>YES</td>
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</table>

Form DFS-F2-DWC-3 (03/2009) Rule 69L-3.025, F.A.C.
DWC-3 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.
## 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**

<table>
<thead>
<tr>
<th><strong>EMPLOYEE NAME</strong> (First, Middle, Last)</th>
<th><strong>DATE OF ACCIDENT</strong> (Month-Day-Year)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>EMPLOYER NAME &amp; ADDRESS</strong></th>
<th><strong>CONCURRENT EMPLOYER NAME &amp; ADDRESS</strong> (If applicable)</th>
<th><strong>ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE?</strong></th>
</tr>
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<tbody>
<tr>
<td></td>
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<td>YES [ ] NO [ ]</td>
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<td><strong>SIMILAR EMPLOYEE'S NAME</strong></td>
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**TELEPHONE**

**TELEPHONE OCCUPATION OF SIMILAR EMPLOYEE**

<table>
<thead>
<tr>
<th><strong>EMPLOYEE'S CUSTOMARY WORK WEEK</strong></th>
<th><strong>EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK</strong></th>
<th><strong>EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK</strong></th>
<th><strong>EMPLOYER'S CUSTOMARY WORK WEEK</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(ex. Saturday thru Friday - Use 7 calendar day period)</td>
<td>(ex. 5 days/week)</td>
<td>(ex. 40 hours/week)</td>
<td>(ex. Saturday thru Friday - Use 7 calendar day period)</td>
</tr>
</tbody>
</table>

### 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.

<table>
<thead>
<tr>
<th><strong>WEEK NO.</strong></th>
<th><strong>WEEK</strong></th>
<th><strong># OF DAYS WORKED THAT WEEK</strong></th>
<th><strong># HOURS WORKED THAT WEEK</strong></th>
<th><strong>GROSS PAY</strong></th>
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</table>

**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**

<table>
<thead>
<tr>
<th>AWW</th>
<th>COMP RATE</th>
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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**

---

Form DFS-F2-DWC-1a (03/2009) Rule 86L-3.025, F.A.C.
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.

Form DFS-F2-DWC-1a (03/2009) Rule 69L-3.025, F.A.C.
Workers’ Compensation Exemptions

Construction Industry
An employer in the construction industry who employs one or more part-time or full-time employees, including the owner, must obtain workers’ compensation coverage.

Corporate officers or members of a limited liability company (LLC) in the construction industry may elect to be exempt if:

- The officer owns at least 10 percent of the stock of the corporation, or in the case of an LLC, a statement attesting to the minimum 10-percent ownership.
- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

No more than three corporate officers per corporation or limited liability member are allowed to be exempt. A $50 fee is required for each application submitted to obtain an exemption. Construction exemptions are valid for a period of two years or until a voluntary revocation is filed or the exemption is revoked by the Division.

Non-Construction Industry
An employer in the non-construction industry, who employs four or more part-time or full-time employees, must obtain workers’ compensation coverage.

Non-construction industry corporate officers may elect to be exempt if:

- The officer is listed as an officer of the corporation in the records of the Florida Department of State, Division of Corporations.
- The corporation is registered and listed as active with the Florida Department of State, Division of Corporations.

There is no limit to the number of corporate officers who can be exempt and there is no application fee. Non-construction exemptions are valid until a voluntary revocation is filed or the exemption is revoked by the Division.

For copies of the exemption form, contact the Division’s Bureau of Compliance at (850) 413-1609 or go to http://www.MyFloridaCFO.com/WC/forms.html and click on Rule 69L-6 and Form number DWC-250, Notice of Election to Be Exempt.

Employees who secure workers’ compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-Free Workplace Program, please call the Division of Workers’ Compensation Customer Service Office at 850-413-1609.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?
A) Yes. You should report all claims of work-related injuries or illnesses to your workers’ compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers’ compensation insurance carrier’s responsibility to investigate all claims and determine if employees are entitled to benefits under Florida’s Workers’ Compensation Law.

Q) Does the employee pay any part of my workers’ compensation insurance premium?
A) No. The law is very specific on this point. It is the employer’s responsibility to pay the entire premium for workers’ compensation.

Frequently Asked Questions

Q) How many days do employees have to report work-related injuries or illnesses?
A) Employers should encourage employees to report accidents as soon as the work-related injuries or illnesses occur. By law, however, employees are required to report work-related injuries or illnesses within 30 days.

Q) To whom should I report the work-related injury?
A) You should report the accident to your insurance company as soon as you have knowledge of the injury. By law, you have seven days from your first knowledge of the work-related injury.

Q) Do I have to report a claim if I do not believe it is a work-related injury or illness?
A) Yes. You should report all claims of work-related injuries or illnesses to your workers’ compensation insurance carrier. This includes claims in which there are no witnesses of the injury or illness. It is your workers’ compensation insurance carrier’s responsibility to investigate all claims and determine if employees are entitled to benefits under Florida’s Workers’ Compensation Law.

Q) Does the employee pay any part of my workers’ compensation insurance premium?
A) No. The law is very specific on this point. It is the employer’s responsibility to pay the entire premium for workers’ compensation.

Employees who secure workers’ compensation coverage can also apply to become a drug-free workplace and may receive a premium discount. To learn more about the Drug-Free Workplace Program, please call the Division of Workers’ Compensation Customer Service Office at 850-413-1609.

Q) Who should I call if my employees have questions or concerns regarding their workers compensation claims?
A) You should first contact your insurance carrier. If your carrier is unable to answer the question or resolve the problem, you or your employees should call the Employee Assistance and Ombudsman Office at 1-800-342-1741.

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.

Questions about workers’ compensation?
Please visit our Web site at www.MyFloridaCFO.com/wc where you will find extensive information such as publications, databases, rules and forms that will give you a better understanding of workers’ compensation.

Employee Assistance and Ombudsman Office Hotline
1-800-342-1741

Injured worker e-mail inquiries
wceao@MyFloridaCFO.com

Customer Service
(850) 413-1601

Employer e-mail inquiries
WorkCompCustomerWFCFO.com

Workers’ Compensation Fraud Hotline
1-800-378-0445
Your workers’ compensation insurance policy covers medical and partial wage-replacement benefits for any employee who sustains a work-related injury or illness. This brochure will give you a better understanding of your role and responsibilities under the workers’ compensation system.

Workers’ Compensation Notice

The law requires that every employer who has secured workers’ compensation coverage post in conspicuous place(s) a notice that contains the employer’s insurance carrier information, the expiration date of the policy, and an anti-fraud statement. The Division of Workers’ Compensation has developed this notice, in poster form, for carriers to provide to their policyholders. Your carrier is required by law to provide you with the poster(s).

Even if employers have purchased workers’ compensation policies, they shall be deemed to have failed to secure workers’ compensation coverage if they have committed any of the following actions:

- materially understated or concealed payroll,
- materially misrepresented or concealed employee duties to avoid proper classification for premium calculations, or
- materially misrepresented or concealed information pertinent to the computation and application of an experience modification factor.

Employers who fail to secure workers’ compensation coverage or fail to update information on their workers’ compensation insurance application are subject to stop work orders and civil and criminal penalties.

First Report of Injury

As soon as you become aware of a work-related injury or illness, immediately contact your workers’ compensation insurance carrier. If you do not report the injury or illness to your insurance carrier within seven days of the date you were informed, you may be subject to an administrative fine not to exceed $2,000 per occurrence. Most insurance policies require that you complete the employee’s signature box.

Disclose all pertinent to the computation and application of an experience modification factor.

Workplace Fatalities

Employers must also report deaths resulting from work-related injuries or illnesses to the Division of Workers’ Compensation within 24 hours. To report a workplace fatality, call 1-800-219-8953 (in Florida) or 850-413-1611, or fax the First Report of Injury or Illness form containing the fatality information to 850-413-1980. To access the form, go to http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1.

Medical Benefits

As soon as you notify your carrier about your employee’s work-related injury, the carrier will:

- Determine the compensability of the injury
- Provide an authorized doctor
- Pay for all authorized medically necessary care and treatment related to the 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’s visits
- Hospitalization
- Physical therapy
- Medical tests
- Prescription drugs
- Prostheses
- Travel expenses to and from authorized providers or pharmacies.

Upon reaching maximum medical improvement (MMI), the employee is required to pay a $10 copayment per visit for medical treatment. MMI occurs when the treating physician determines that the employee’s injury has healed to the extent that further improvement is not likely.

Wage Replacement Benefits

Workers’ compensation benefits for lost wages will start on the eighth day that the injured employee is unable to work. The injured employee will not receive wage replacement benefits for the first seven days of work missed, unless he or she is out of work for more than 21 days due to the work-related injury. In most cases, the wage-replacement benefits will equal two-thirds of the employee’s pre-injury weekly wage, but the benefit will not be higher than Florida’s average weekly wage. If the employee qualifies for wage replacement benefits, he or she can expect to receive the first benefit check within 21 days after the carrier becomes aware of the injury or illness, and bi-weekly thereafter. The injured employee will be eligible for different types of wage replacement benefits, depending on the progress of the claim and the severity of the injury.

Temporary Total Benefits: These benefits are provided as a result of an injury that temporarily prevents the employee returning to work and the employee has not reached MMI.

Temporary Partial Benefits: These benefits are provided when the worker releases the employee to return to work, and the employee has not reached MMI and earns less than 80 percent of the pre-injury wage. The benefit is equal to 80 percent of the difference between 80 percent of the pre-injury wage and the post-injury wage. The maximum length of time the injured employee can receive temporary 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 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. If you return to work at or above your pre-injury wage, the permanent impairment benefit is reduced by 50%.

Permanent Total Benefits: These benefits are provided when the injury causes the employee to be permanently and totally disabled according to the conditions stated in law.

Death Benefits: Compensation for deaths resulting from work-related injuries or illnesses include payment of funeral expenses and dependency benefits (each is subject to limits defined by law). A dependent spouse may also be eligible for job training benefits.

Wage Statement Form

You must complete and provide a wage statement form (DFS-F2-DWC-1a) to your carrier for any employee who is entitled to wage replacement benefits, within 14 days of the date of the accident. You must also complete this form upon the termination of the employee or upon termination of fringe benefits for any employee who is collecting wage replacement benefits within seven days of such termination. To access the form go to, http://www.MyFloridaCFO.com/WC/forms.html and click on DWC-1a.

Employee Assistance Office

If you have any questions or concerns about your employer’s wage replacement benefits, call your insurance carrier’s claim adjuster. If the insurance carrier does not provide the information that you have requested, you can call the Division of Workers’ Compensation, Employee Assistance Office (EAO) at 1-800-342-1741. This office helps prevent and resolve disputes between injured workers and employers/carriers.

There are several services that you can call or visit. You can find EAO statewide locations at www.MyFloridaCFO.com/WC/organization/eao.html. In addition, there is a Workers’ Compensation Fraud hotline at 1-800-378-0445.

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 employers’ workers’ compensation insurer, 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/ico/forms.asp.

Anti-Fraud Reward Program

Workers’ compensation fraud occurs when any person knowingly or 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.
Certificado de elección para exenciones

Industrias dedicadas a la construcción

Empleadores en las industrias de la construcción con un (1) empleado o más a jornada completa o jornada parcial, incluyendo el dueño, debe obtener la cobertura de seguro por accidentes de trabajo.

Oficiales o miembros de una sociedad de responsabilidad limitada (LLC) en la industria de la construcción pueden elegir ser exentos si:

- Poseen un mínimo de diez por ciento (10%) de titularidad de acciones de la corporación o en el caso de un LLC hay una declaración que da testimonio a la propiedad del 10 por ciento mínimo.
- El oficial de la compañía aparece como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación aparece activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

Solamente tres oficiales de una corporación o sociedades de responsabilidad limitada pueden elegir ser exentos. Se requiere pagar $50 por cada aplicación presentada para obtener una exención. Exenciones en las industrias que participan en la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.


Industrias que no se dedican a la construcción

Un empleador que no participa en la industria de construcción y tiene cuatro (4) empleados o más de jornada completa o jornada parcial tiene que obtener la cobertura de seguros por accidentes de trabajo.

Propietarios únicos y socios en industrias que no participan en la construcción están automáticamente exentos de la ley, pero pueden elegir ser cubiertos.

Oficiales de una corporación que no se dedica a la construcción puede elegir ser exentos si:

- El oficial esta listado como oficial de la corporación en el registro del Departamento del Estado de la Florida, División de Corporaciones.
- La corporación esta listada activa en el registro del Departamento del Estado de la Florida, División de Corporaciones.

No hay límite de oficiales que pueden ser elegibles para ser exentos y no le cobrarán por llenar la aplicación para la exención. Exenciones en las industrias que no se dedican a la construcción son válidas por dos años o hasta que se registre una revocación voluntaria o si la exención es revocada por la división.

Preguntas hechas con frecuencia

P) ¿Cuántos días tienen los empleados para reportar lesiones u enfermedades relacionadas con el trabajo?
R) Los patrones deben aconsejar a sus empleados que reporten accidentes tan pronto como ocurran lesiones o enfermedades relacionadas con el trabajo. Por ley, sin embargo, se requiere que empleados reporten lesiones o enfermedades relacionadas con el trabajo en el plazo de 30 días.

P) ¿A quién le debo reportar la lesión relacionada con el trabajo?
R) Usted debe reportar el accidente a su compañía de seguros tan pronto usted tenga conocimiento de la lesión. Por ley, usted tiene siete días desde su primer conocimiento de la lesión relacionada con el trabajo.

P) ¿Tengo que reportar un reclamo si no creo que la lesión o enfermedad ocurrió en el trabajo?
R) Sí. Usted debe reportar todas las demandas de lesiones o enfermedad relacionadas con el trabajo a su compañía de seguros. Esto incluye las demandas de las cuales no hay testigos de las lesiones u de las enfermedades. Es responsabilidad de la compañía de seguros por accidentes de trabajo investigar todas las demandas y determinar si el empleado tiene derecho a recibir beneficios de acuerdo a la ley de seguros por accidentes de trabajo.

P) ¿El empleado paga parte de la prima de seguro por accidentes de trabajo?
R) No. La ley es muy específica en este punto. Es la responsabilidad del empleador pagar la prima entera del seguro por accidentes de trabajo.

P) ¿A quién debo llamar si mis empleados tienen preguntas o preocupaciones con respecto a sus reclamaciones?
R) Usted debe primero contactar a su compañía de seguro. Si la aseguradora no puede contestar la pregunta o resolver el problema, usted o sus empleados deben llamar a la oficina de la ayuda al Trabajador en 1-800-342-1741.

Empleadores que adquieran una póliza de seguros por accidentes de trabajo pueden también aplicar para ser un lugar de trabajo libre de drogas y pueden recibir un descuento de prima. Para aprender más sobre el programa, llame por favor a la División de Compensación por Accidentes, la oficina del servicio de atención al cliente al 850-413-1609.

Limitación de responsabilidad

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

INFORMACIÓN IMPORTANTE

DEL SEGURO DE INDEMNIZACIÓN POR ACCIDENTES DE TRABAJO PARA LOS EMPLEADORES DE LA FLORIDA

69L-3.0036, F.A.C. Employer Informational Brochure
Rule 69L-3.025, F.A.C. Forms
DFS-F2-DWC-66
Revised March 2010
**Su póliza de seguro por accidentes de trabajo cubre beneficios médicos y reemplazo parcial del salario para cualquier empleado que sostenga lesión o enfermedad relacionada con su trabajo.**

**Esto le dará una mejor comprensión de su papel y responsabilidades bajo el sistema de seguro por accidentes de trabajo.**

**Aviso de seguro por accidentes de trabajo**

La ley requiere que cada empleador que ha adquirido una póliza de seguro por accidentes de trabajo coloque en un lugar o lugares conspicuo(s) un aviso que contenga información sobre la compañía de seguros, la fecha de vencimiento de la póliza, y una declaración en contra de fraude. La División de Compensación por Accidentes de Trabajo ha desarrollado este aviso en forma de cartel, para que las compañías de seguro se las proporcione a sus asegurados. Su compañía de seguros tiene obligación legal de proveerle estos carteles.

Aunque el empleador adquiera una póliza de seguros por accidentes de trabajo, se considerarán no hecho si han cometido cualquiera de las siguientes acciones:

- **subestimar o ocultar nómina de pago.**
- **falsificar u ocultar las responsabilidades del empleado para evitar la clasificación apropiada para los cálculos de la prima de seguro.**
- **falsificar u ocultar información pertinente a Cálculo y aplicación de un factor de modificación de experiencia.**

Los empleadores que tienen obligación de proveer seguro por accidentes de trabajo pero no lo hacen o no actualizan la información reportada en la solicitud de seguro por accidentes de trabajo, son sujetos a una orden de suspensión de trabajo y penas civiles y criminales.

**Primer reporte de la lesión o enfermedad**

Tan pronto usted se entera de una lesión o enfermedad relacionada con un accidente en el lugar de trabajo, contacte a su compañía de seguros por accidentes de trabajo. Si usted no reporta la lesión o la enfermedad a la compañía de seguro en un plazo de siete días después de la lesión o enfermedad, su compañía de seguros no puede otorgar beneficios de reemplazo de salario (DWC-1) a nadie excepto a usted.

Usted también puede completar el primer reporte de la lesión u enfermedad (DWC-2) para cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto debe hacerse en un plazo de 7 días de tal terminación.


**Beneficios médicos**

Tan pronto usted le notifique a la compañía de seguro sobre la lesión o enfermedad, la compañía de seguros, la compañía:

- **Determine si la lesión es compensable.**
- **Proporcionar un solo cambio de médico dentro de cinco jornadas laborales del recibo de la petición de seguro.**
- **Atención médica y tratamientos autorizados pueden incluir:**
  - Consultas médicas
  - Hospitalización
  - Terapia física
  - Exámenes médicos
  - Medicamentos recetados
  - Pruebas
  - Gastos de ida y vuelta por viajes a consultas médicas o tratamientos autorizados

En cuanto usted alcance la máxima mejoría médica (MMI), deberá completar y suministrar a la compañía de seguros un Formulario de la declaración del salario (DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario.

**Beneficios de reemplazo de salario**

Los empleados que sufrieron una lesión u enfermedad a un empleado que no pueda trabajar. El empleado lesionado no recibirá beneficio de reemplazo de salario por los primeros siete días laborales perdidos. No se puede trabajar a menos que ha estado incapacitado por más de 21 días debido a su lesión u enfermedad relacionada con su empleo. En la mayoría de los casos, los beneficios de reemplazo de salario se pagan por un máximo de 260 días (200/32) del salario semanal regulares del empleado antes de sufrir la lesión o enfermedad, pero el beneficio no excede el promedio de los salarios semanales en la Florida. Si el empleado no trabaja para el empleado él o ella puede esperar recibir el primer cheque dentro de 21 días después de que la compañía de seguros se entere de la lesión o enfermedad. Los siguientes cheques se les enviarán cada dos semanas. El empleado lesionado será elegible para diversos tipos de beneficios de reemplazo de salario dependiendo del progreso del reclamo y de la severidad de la lesión.

- **Beneficios Por incapacidad total temporal (TTD por su sigla en inglés)**: Estos beneficios son proveídos como resultado de una incapacidad temporal que no se anticipa que el empleado vuelva a trabajar, y el empleado 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 al empleado volver a trabajar, el empleado no ha alcanzado la máxima mejoría médica, y gana menos del 80% del salario que ganaba antes de sufrir la lesión o enfermedad. El beneficio es igual al 80% de la diferencia entre el 80% del salario de antes de la lesión y del salario después de la lesión. El periodo máximo que el empleado lesionado puede recibir beneficios temporales es 104 semanas o hasta que la fecha del MMO sea determinada, lo que ocurra primero.

- **Beneficios por daños permanentes (BD por su sigla en inglés)**: Estos beneficios son proveídos cuando la lesión o enfermedad causa cualquier pérdida física, psicológica o funcional y el impedimento existe después de la fecha de la máxima mejoría médica (MMI). Un médico asignará una valoración de incapacidad permanente a la lesión que será expresada como un porcentaje.

- **Beneficios por incapacidad total permanente (PTD por su sigla en inglés)**: Estos beneficios son provistos cuando el médico le indica que el empleado no puede volver a trabajar. El empleado no ha alcanzado la máxima mejoría médica. 

**Formulario de la declaración del salario**

Usted debe llenar el formulario de la declaración del salario (DFS-F2-DWC-1a) para cualquier empleado que tenga derecho a recibir beneficios de reemplazo de salario. La compañía de seguros debe hacer una copia del formulario y proveerlo al empleado dentro de 14 días después del conocimiento del accidente. Usted debe llenar el formulario al despido o al dejar de proveer beneficios a cualquier empleado que esté recibiendo beneficios de reemplazo del salario. Esto se debe hacer en un plazo de 7 días de tal terminación.


**Oficina de ayuda al trabajador**

Si usted tiene alguna pregunta o preocupaciones sobre los beneficios que ofrece el seguro por accidentes de trabajo, llame a su compañía de seguros. Si la compañía de seguros no ofrece la información que usted ha pedido, usted puede llamar la División de Compensación por Accidentes de Trabajo, oficina de Ayuda al Empleado (EAO) al 1-800-342-1741. Esta oficina ayuda a prevenir y a resolver disputas entre los trabajadores y los empleadores/las compañías de seguros.

Los especialistas de la EAO poseen conocimiento sobre el seguro por accidentes de trabajo y/o lugares donde pueden contestar sus preguntas. EAO tiene oficinas en todo el estado que puede llamar o visitar. Usted puede localizar el lugar donde están estas oficinas visitando el sitio: web http://www.MyFloridaCFO.com/WC/oranization/eao_offices.html.


**Petición para beneficios**

Para comenzar el proceso judicial para solicitar beneficios que se le deben según la ley pero la compañía de seguros no los ha proveído, se debe presentar el Formulario de la Déclaración del Salario (DWC-1) o el Formulario para Beneficios (Petición para beneficios) a la Oficina de los Juicios de las reclamaciones de compensación. Se puede conseguir el formulario visitando el sitio Web: www.jcc.state.fl.us/jcc/ form/filefinder.html.

**Programa de recompenza contra fraude**

El fraude en el seguro por accidentes de trabajo ocurre cuando cualquier persona a sabiendas y con intención de hacer daño, dafraudo o engañar a cualquier empleador o trabajador, compañía de seguros, o auto compañía de seguros. Este fraude puede resultar en fraude de hasta $25,000.00 se les puede pagar a personas quienes proveen información que resulte en la detención y la condena de personas que han cometido fraude de seguros. Llame al 1-800-378-0445 para reportar sospechas de fraude por accidentes de trabajo.
NOTICE

Post Accident Drug/Alcohol Policy

Builders Mutual Insurance Company implemented a post accident drug/alcohol testing policy. As a policyholder of Builders Mutual, you are required to comply with this policy. Implementation of a drug and alcohol testing program can help protect your financial interest, your employees and your job sites.

BMIC’s Drug/Alcohol Testing Policy will first and foremost prevent individuals with a drug or alcohol dependency from abusing the workers’ compensation system and using your dollars to sustain an illegal habit. Individuals with drug and alcohol dependency also pose a threat to fellow employees, supervisors, and the general public as their actions can cause harm to those around them. Lastly, substance abuse can lead to criminal conduct to finance the habit.

After each work related injury, a drug and alcohol test should be performed on the injured employee and all other employees whose conduct could have contributed to the accident if there is a reasonable possibility that drug and/or alcohol use by the injured employee and/or co-employees could have contributed to the injury or illness. The test will be performed at the time medical treatment is first administered and the cost of the test will be covered by Builders Mutual as a reasonable claims expense.

If the treating medical facility refuses to administer a drug and alcohol test, contact the Claims department at 1-800-809-4862 while the injured is still at the facility. This will enable the Claims department to contact the provider to make arrangements to have a drug and alcohol test administered.

If you have any questions regarding this policy, please contact the Claims department at 1-800-809-4861.
BMIC Drug Testing Acknowledgment

I have read and understand the Policy of Builders Mutual Insurance Company that all employees of policyholders shall be tested for drugs or alcohol if the employee is involved in an alleged work-related accident which might give rise to the filing of a workers’ compensation claim. I am an employee of a policyholder and I consent and agree to be tested for the use of alcohol, drugs, or illegal, non-prescribed controlled substances in the event of an alleged work-related accident. I understand that if I do not agree to be tested or submit to any procedure to detect the use of alcohol, drugs, or illegal, non-prescribed substances this will be deemed an admission of impairment by such substances and I understand that when applicable by state law, my workers’ compensation claim may be denied or benefits reduced. I understand that if the results of the test are positive for drugs or alcohol, my claim for workers’ compensation benefits may be denied.

I hereby acknowledge receipt of this Policy concerning drug and alcohol testing.

This ____ day of ________________, _______.   ____________________________

Employee Signature

____________________________

Employee Name (Print)

____________________________

Policyholder Representative Signature
AVISO
Reglamento de Examen de Drogas y Alcohol

Builders Mutual, su compañía de seguros, implementó una regla que requiere que todos los empleados lesionados en el trabajo se hagan un examen de drogas y alcohol. Como un asegurado por Builders Mutual, usted está obligado a cumplir con esta reglamentación. El programa de examen de drogas y alcohol puede proteger sus intereses financieros, sus empleados, y su lugar de trabajo.

Nuestra política de examen de drogas y alcohol evitará el abuso del sistema de compensación laboral por parte de empleados con dependencia a drogas o alcohol. Las personas con dependencia a drogas y alcohol también pueden perjudicar el bienestar de otros empleados, supervisores, y del público general, además de que sus acciones pueden causar daño a todos los que le rodean. El abuso de sustancias ilegales puede resultar en actos criminales con el propósito de mantener una adicción.

Después de cada lesión relacionada con el trabajo, se debe realizar un examen de drogas y/o alcohol al empleado lesionado y a todos los empleados cuyo comportamiento pudo haber afectado el accidente, si existe la posibilidad del uso de drogas y/o alcohol por parte del empleado lesionado y/o los colaboradores pudo haber contribuido a la lesión o enfermedad. Este examen debe ser hecho en la primera consulta médica sin ningún costo para el empleado. Builders Mutual pagará por el examen.

Si por alguna razón la clínica se niega a hacer el examen, contacte nuestro departamento de reclamos mientras que su empleado todavía está en la facilidad médica. Nosotros tendremos la oportunidad de contactar la clínica directamente y hacer arreglos para que se haga el examen.

Si usted tiene alguna pregunta acerca de esta reglamentación, por favor contactenos al departamento de reclamos al 1-800-809-4861.
He leído la política del examen de drogas y alcohol de la compañía de seguros Builders Mutual. Entiendo que todas las personas aseguradas se le harán examenes de drogas y alcohol si tienen un accidente en el trabajo y que potencialmente resultaría en un reclamo bajo la póliza de compensación laboral. Soy un empleado bajo esta póliza y doy consentimiento/autorización para que me hagan pruebas de drogas y alcohol en caso de un reclamo de accidente bajo esta póliza. Entiendo que si me niego a tomar el examen para detectar estas sustancias, automáticamente, estaría admitiendo que he consumido drogas o alcohol. De acuerdo con la ley de este estado, esto podría resultar en el rechazo o la reducción de los beneficios del reclamo. También, entiendo que si los resultados de estas pruebas son positivos, el reclamo podría ser anulado.

Confirmo que he recibido esta información acerca del reglamento de examenes de drogas y alcohol.

En este día __________ de ________ del 20___.

____________________________________
Firma del empleado

____________________________________
Nombre de empleado

____________________________________
Firma del asegurado
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.

Builders Mutual Insurance Company
Report a claim by phone: 1-800-809-4859
Report a claim by email: wcnoticeofloss@bmico.com
Compensación por accidentes de trabajo labora para usted:

Si usted se lastima en su lugar de empleo:

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 más 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 médicas 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.
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.