

NOTICE OF ACTION/CHANGE

DIVISION OF WORKERS' COMPENSATION

Attention: Information Management

200 East Gaines Street
Tallahassee, FL 32399-4226

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

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

SENT TO DIVISION DATE	DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE ✍

SOCIAL SECURITY NUMBER	EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT (Month-Day-Year)
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INDICATE ONLY ACTION OR CHANGE - PLEASE REFER TO KEY FOR DWC-4 TYPES/CODES ON REVERSE SIDE

ALL INDEMNITY SUSPENDED:	EFFECTIVE DATE	_____ - _____ - _____	REASON CODE:	_____
INDEMNITY REINSTATED AFTER SUSPENSION:	EFFECTIVE DATE	_____ - _____ - _____	DISABILITY TYPE:	_____

RELEASED TO RETURN TO WORK DATE:	_____ - _____ - _____	RESTRICTIONS?:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ACTUAL RETURN TO WORK DATE:	_____ - _____ - _____	RESTRICTIONS?:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
DATE FINAL SETTLEMENT ORDER MAILED:	_____ - _____ - _____			
OVERALL MMI DATE:	_____ - _____ - _____	PI RATING:	_____ % BAW	DATE OF DEATH _____ - _____ - _____

PERMANENT IMPAIRMENT BENEFITS (D/A'S PRIOR TO 01/01/94):	DATE PAID:	_____ - _____ - _____	
IMPAIRMENT INCOME BENEFITS (D/A'S ON OR AFTER 01/01/94):	START DATE:	_____ - _____ - _____	WEEKLY RATE: \$ _____
			TOTAL NUMBER OF WEEKS OF ENTITLEMENT: _____

PERMANENT TOTAL:	DATE ACCEPTED/ADJUDICATED	_____ - _____ - _____	AVERAGE WEEKLY WAGE AND/OR COMPENSATION RATE AMENDMENTS:
	WEEKLY PT SUPPLEMENTAL RATE	\$ _____	PREVIOUS AWW: \$ _____
	WEEKLY PT SUPP EFFECTIVE DATE	_____ - _____ - _____	PREVIOUS COMP RATE: \$ _____

BENEFIT ADJUSTMENTS

BENEFIT ADJUSTMENT CODE	_____	BENEFIT ADJUSTMENT CODE	_____	AMENDED AWW: \$ _____
DISABILITY TYPE ADJUSTED	_____	DISABILITY TYPE ADJUSTED	_____	AMENDED COMP RATE: \$ _____
WEEKLY ADJ AMOUNT \$	_____	WEEKLY ADJ AMOUNT \$	_____	RETROACTIVE TO D/A: <input type="checkbox"/> YES <input type="checkbox"/> NO
EFFECTIVE DATE	_____	EFFECTIVE DATE	_____	IF NO, GIVE EFFECTIVE DATE: _____ - _____ - _____
ADJUSTMENT END DATE	_____	ADJUSTMENT END DATE	_____	

CORRECTIONS OF:	CLASS CODE
<input type="checkbox"/> SOCIAL SECURITY NUMBER/CORRECT #: _____	
<input type="checkbox"/> DATE OF ACCIDENT/CORRECT DATE: _____ - _____ - _____	
<input type="checkbox"/> EMPLOYEE'S NAME/CORRECT NAME: _____	
<input type="checkbox"/> CLAIMS-HANDLING ENTITY: _____	
	NAICS CODE

REMARKS:

CC:	
	INSURER NAME

INSURER CODE #	DATE PREPARED: (Month-Day-Year)	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
	_____ - _____ - _____	

SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	

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.

KEY FOR DFS-F2-DWC-4 TYPES / CODES

DISABILITY TYPES:

- TT - Temporary Total Disability Benefits
- TTC - Temporary Total Disability Benefits at 80% for severe injuries per Section 440.15(2)(b), FS.
- TTE - Temporary Total Benefits while in an approved training and education program
- TP - Temporary Partial Disability Benefits
- PI - Permanent Impairment Benefits (Dates of Accident from 08/01/79 through 12/31/93)
- IB - Impairment Income Benefits (Dates of Accident on or after 01/01/94)
- WL - Wage Loss Benefits (Dates of Accident from 08/01/79 through 12/31/93)
- SB - Supplemental Benefits (Dates of Accident on or after 01/01/94)
- PT - Permanent Total Disability Benefits
- DB - Death Benefits

SUSPENSION REASON CODES:

(All Indemnity Benefits have been suspended because:)

- S1 - The employee returned to work, or was medically released to return to work
- S2 - The employee did not comply with medical treatment requirements in the Workers' Compensation Law / Rules
- S3 - The employee did not comply with administrative requirements in the Workers' Compensation Law / Rules
- S4 - The employee died
- S5 - The employee became incarcerated in a public institution
- S6 - The employee's whereabouts are unknown
- S7 - The employee's benefits have been used up or entitlement to those benefits has ended
- S8 - The employee' claim has been changed to another jurisdiction

BENEFIT ADJUSTMENT CODES:

(The employee's rate of pay is being reduced or adjusted because of:)

- A - Apportionment / Contribution from another insurer
- B - Subrogation / Third Party Recovery
- C - Overpayment of Benefits from the insurer
- H - Child Support Payment
- N - Employee not complying with Medical or Training and Education requirements
- P - Carrier taking credit for an advance given to the employee
- R - Social Security Retirement Benefits received by the employee
- S - Social Security Disability Benefits received by the employee
- U - Unemployment Compensation Benefits received by the employee
- V - A Safety Violation by the employee
- X - A change in the dependents entitled to Death Benefits

DWC-4 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.