

FIRST REPORT OF INJURY OR ILLNESS REPORT ONLY

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

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

Report all deaths within 24 hours, 1-800-219-8953 or (850) 922-8953

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

PLEASE PRINT OF TYPE

EMPLOYEE INFORMATION

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

EMPLOYER INFORMATION

COMPANY NAME Lake County Board of County Commissioners D.S.A.: Employee Services		FEDERAL I.D. NUMBER(FEIN) 596000695	DATE FIRST REPORTED (Month/Day/Year)
Street: 315 W. MAIN STREET, PO BOX 7800		NATURE OF BUSINESS GOVERNMENTAL	POLICY/MEMBER NUMBER
City: TAVARES	State: FL	Zip: 32778-7800	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
TELEPHONE	Area Code	Number	DATE EMPLOYED ____/____/____
352-343-9596		EMPLOYER'S LOCATION ADDRESS (if different) Street: _____ City: _____ State: _____ Zip: _____	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
LOCATION # (if applicable) _____		LAST DATE EMPLOYEE WORKED ____/____/____	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ____/____/____
PLACE OR ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: _____ Zip: _____		DATE OF DEATH(if applicable) ____/____/____	RATE OF PAY <input type="checkbox"/> HR <input type="checkbox"/> WK \$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
COUNTY OF ACCIDENT _____		AGREE WITH DESCRIPTION OF ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	Number of hours per day _____ Number of hours per week _____ Number of days per week _____
Any person who, knowingly and with intent to injure, defraud, or deceive any employer, 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 440.107(7), F.S. I have reviewed, understand and acknowledge the above statement.			NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
EMPLOYEE SIGNATURE (if available to sign) _____		DATE _____	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER SIGNATURE _____		DATE _____	

CLAIMS-HANDLING ENTITY INFORMATION

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 Employee's 8th Day of Disability _____/_____/_____
Entity's Knowledge of 8th Day of Disability _____/_____/_____

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 1st Payment \$ _____ Interest Amount Paid in 1st Payment \$ _____

REMARKS:			INSURER NAME
INSURER CODE # 9808	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE 921190	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE Employers Mutual, Inc 700 Central Parkway Stuart, FL 34994 Tele: 1-800-431-2221 Fax: 1-772-220-1637
SERVICE CO/TPA CODE # 6060	CLAIMS-HANDLING ENTITY FILE #		