

EMPLOYEE EARNINGS REPORT

Carrier Code 694

CARRIER RECEIVED DATE

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.

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)				
EMPLOYEE'S NAME (First, Middle, Last)	EMPLOYEE'S SOCIAL SECURITY NUMBER	DATE OF ACCIDENT		
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CARRIER/SVC. CO. NAME & ADDRESS Department of Financial Services Division of Risk Management Post Office Box 8020 Tallahassee, FL 32314-8020		
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? <input type="checkbox"/> YES (IF YES, COMPLETE FORM, DATE & RETURN) <input type="checkbox"/> 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? <input type="checkbox"/> YES, (IF YES, COMPLETE INFORMATION BELOW) <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO				
BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE				
DATES SELF-EMPLOYED		DATES SELF-EMPLOYED		
FROM	TO	WAGES, INCOME OR BENEFITS RECEIVED	FROM	TO
V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? <input type="checkbox"/> YES (IF YES, STATE AMOUNTS) <input type="checkbox"/> 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 carrier, etc? Attach additional documentation if necessary. <input type="checkbox"/> YES (IF YES, STATE AMOUNTS) <input type="checkbox"/> NO				
PERIOD BENEFITS RECEIVED				TOTAL AMOUNT
SOURCES OF WAGES, INCOME OR BENEFITS	FROM	TO		
Any person, who knowingly and with intent of injure, defraud, or deceive any employer, or employee, insurance company pr self-insured program, Files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.				
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 Florida Department of Financial Services Bureau of State Employees' WC Claims Post Office Box 8020 Tallahassee, FL 32314-8020 (850)413-3123	
TITLE	DATE			