

# MODULE: AVERAGE WEEKLY WAGE CALCULATION

Division of Workers' Compensation  
Bureau of Monitoring and Audit

## AVERAGE WEEKLY WAGE (AWW)

s. [440.14, F.S.](#), [Rule 69L-3.30046, F.A.C.](#)

### Average Weekly Wage (AWW)

- The amount of money the injured worker (IW) earns each week
- It is the basis for all monetary benefits being paid to the injured worker
- It is the single most important factor in the value of the workers' compensation claim

### Wage Statement

- The employer reports all required wage information of the injured worker on the [DFS-F2-DWC-1a](#) form to the claim administrator within 14 days of the employer's knowledge of a Lost-Time or a medical to Lost-Time case
- The whole of 13 weeks of the injured worker's wages immediately preceding the date of accident are used to calculate AWW
- If 13 weeks of the injured worker's wages are not available, then at least 75% of the total customary hours of employment which equates to 9.75 weeks (10 weeks can be utilized)

## AWW (continued)

- If the injured worker has not worked in such employment during substantially the whole of 13 weeks immediately preceding the accident, the wages of a similar employee in the same employment can be used
- If the injured worker is a seasonal worker and the prior methods cannot fairly be applied in determining the AWW, the employer may use the calendar year or the 52 weeks immediately preceding the accident.
- If any of the prior methods cannot reasonably and fairly be applied, the full-time weekly wages of the injured worker can be used
- An interactive [DFS-F2-DWC-1a](#) can be found on the Division's website.

**WAGE STATEMENT**  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**

RECEIVED BY: CLAIMS HANDLING ENTITY

**NOTICE TO EMPLOYEE:** If you have any questions about the information contained on this form, please contact your employer or claimhandling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-362-1741.

**PLEASE PRINT OR TYPE**

EMPLOYEE NAME (FNU, MIDDLE, LAST)		DATE OF ACCIDENT (Month/Day/Year)
EMPLOYER NAME & ADDRESS	CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? YES _____ NO _____
TELEPHONE	TELEPHONE	SIMILAR EMPLOYEE'S NAME
TELEPHONE	TELEPHONE	OCCUPATION OF SIMILAR EMPLOYEE
EMPLOYEE'S CUSTOMARY WORK WEEK <small>(If not applicable, then state "not applicable")</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED WEEK <small>(If not applicable, then state "not applicable")</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED WEEK <small>(If not applicable, then state "not applicable")</small>
<b>NOTICE TO EMPLOYER:</b> Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claimhandling 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 discover a mistake involving any fringe benefits, you must file a corrected form. Information and your obligation to file a wage statement is also provided on the back of this form.		

**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.**

WEEK NO.	DATE		# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	EMPLOYER'S CONTRIBUTION TO HEALTH INSURANCE	EMPLOYER'S CONTRIBUTION TO PENSION/RETIREMENT
	FROM	TO					
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
**							

**ENTER THE FORM TO:**  
 (Circle the entity name, Address & Telephone #)

TOTAL	WILL EMPLOYER CONTRIBUTE TO PROVIDE ABOVE BENEFITS? YES _____ NO _____
TOTAL FRINGE BENEFITS \$	
TOTAL OF GROSS PAY, GRATUITIES AND FRINGES \$	
(FOR CLAIMS HANDLING ENTITY USE ONLY)	AWW COMPACT

Any person who, knowingly and with intent to defraud, defraud or deceive any employer or employee, insurance company, or self-insured program, from 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.

PROFESSOR/CLASS \_\_\_\_\_ TELEPHONE # \_\_\_\_\_ DATE \_\_\_\_\_

Form DFS-F2-DWC-1a (04/2006)

**Lost-Time Claim Scenario #1**

DOI: 3-16-18

Date Disability Began: 6-17-18

Waiting Week: 6-17- to 6-23-18

Employer wage statement provided includes 13 weeks of earnings preceding the accident = \$6,825.

What is the AWW?

*Gross total /weeks*

*\$6,825/13= \$525.00 (AWW)*

What is the Comp Rate (CR)?

*Calculation of CR*

*AWW x .6667*

*\$525.00 x .6667= \$350.02*

***\$525.00 (AWW) and \$350.02 (CR)***

**WAGE STATEMENT**  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**

RECEIVED BY CLAIMS-HANDLING ENTITY

**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**

EMPLOYEE NAME (First, Middle, Last): **Injured Employee A**      DATE OF ACCIDENT (Month-Day-Year): **03/16/2018**

EMPLOYER NAME & ADDRESS: **Anderson Grocers  
100 East Gaines Street  
Tallahassee, FL 32399**      CONCURRENT EMPLOYER NAME & ADDRESS (if applicable):  
 ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE?  YES  NO  
 SIMILAR EMPLOYEE'S NAME:

TELEPHONE: **(850) 867-5309**      TELEPHONE:      OCCUPATION OF SIMILAR EMPLOYEE: **Cashier**

EMPLOYEE'S CUSTOMARY WORK WEEK: **Monday - Friday**      EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK: **5**      EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK: **40**      EMPLOYEE'S CUSTOMARY WORK WEEK: **Saturday-Friday**  
(ex. Saturday thru Friday - Use 7 calendar day period)      (ex. 8 AM - 4:00 PM)      (ex. all hours / week)      (ex. Saturday thru Friday - Use 7 calendar day period)

**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.						GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (EMPLOYEE FICA)	
WEEK NO.	FROM	TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY		HEALTH INSURANCE	RENT/HOUSING
1	12/17/2017	12/21/2017	5	40	525.00			
2	12/24/2017	12/28/2017	5	40	525.00			
3	12/31/2017	01/04/2018	5	40	525.00			
4	01/07/2018	01/11/2018	5	40	525.00			
5	01/14/2018	01/18/2018	5	40	525.00			
6	01/21/2018	01/25/2018	5	40	525.00			
7	01/28/2018	02/01/2018	5	40	525.00			
8	02/04/2018	02/08/2018	5	40	525.00			
9	02/11/2018	02/15/2018	5	40	525.00			
10	02/18/2018	02/22/2018	5	40	525.00			
11	02/25/2018	03/01/2018	5	40	525.00			
12	03/04/2018	03/08/2018	5	40	525.00			
13	03/11/2018	03/15/2018	5	40	525.00			
**								

RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)

TOTAL: **6825.00**

WILL EMPLOYER CONTRIBUTE TO PROVIDE ABOVE BENEFITS?  YES  NO

TOTAL FRINGE BENEFITS: **† 0.00**

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES: **† 6825.00**

(FOR CLAIMS-HANDLING ENTITY USE ONLY)      AWW: **525.00**      COMP RATE: **350.02**

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.

PREPARED BY: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_ DATE \_\_\_\_\_  
 Form DFS-P2-DWC-1a (03/2009) Rule 69L-3.025, F.A.C.

**Lost-Time Claim Scenario #2**

DOI: 3-16-18

Date Disability Began: 6-17-18

Waiting Week: 6-17- to 6-23-18

Employer wage statement provided includes 10 weeks of earnings preceding the accident = \$5,250.00

What is the AWW?

*Gross total /weeks*

*\$5,250/10= \$525.00 (AWW)*

What is the Comp Rate (CR)?

*Calculation of CR*

*AWW x .6667*

*\$525.00 x .6667= \$350.02*

***\$525.00 (AWW) and \$350.02 (CR)***

**WAGE STATEMENT**  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**

RECEIVED BY CLAIMS-HANDLING ENTITY

**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**

EMPLOYEE NAME (First, Middle, Last) Injured Employee A		DATE OF ACCIDENT (Month-Day-Year) 03/16/2018
EMPLOYER NAME & ADDRESS Anderson Grocers 100 East Gaines Street Tallahassee, FL 32399	CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
TELEPHONE (850) 867-5309	TELEPHONE	SIMILAR EMPLOYEE'S NAME
EMPLOYEE'S CUSTOMARY WORK WEEK Monday - Friday <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK 5 <small>(ex. 8 AM / noon)</small>	OCCUPATION OF SIMILAR EMPLOYEE Cashier
	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK 40 <small>(ex. all hours / week)</small>	EMPLOYEE'S CUSTOMARY WORK WEEK Saturday-Friday <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>

**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.						GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (EMPLOYEE FICA)	
WEEK NO.	FROM	TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY		EMPLOYER COST ONLY	
1	01/07/2018	01/11/2018	5	40	525.00		HEALTH INSURANCE	RENT/HOUSING
2	01/14/2018	01/18/2018	5	40	525.00			
3	01/21/2018	01/25/2018	5	40	525.00			
4	01/28/2018	02/01/2018	5	40	525.00			
5	02/04/2018	02/08/2018	5	40	525.00			
6	02/11/2018	02/15/2018	5	40	525.00			
7	02/18/2018	02/22/2018	5	40	525.00			
8	02/25/2018	03/01/2018	5	40	525.00			
9	03/04/2018	03/08/2018	5	40	525.00			
10	03/11/2018	03/15/2018	5	40	525.00			
11								
12								
13								
**								

RETURN THIS FORM TO:  
 (Claims-handling entity Name, Address & Telephone #)

TOTAL: 5250.00

WILL EMPLOYER CONTRIBUTE TO PROVIDE ABOVE BENEFITS?  
 YES  NO  YES  NO

TOTAL FRINGE BENEFITS: \$ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES: \$ 5250.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW: 525.00      COMP RATE: 350.02

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 69L-3.025, F.A.C.

**Lost-Time Claim Scenario #3**

DOI: 3-16-18

Date Disability Began: 6-17-18

Waiting Week: 6-17- to 6-23-18

Employment date: 03/10/2018

The employee has only worked for 5 days, therefore 13 weeks of wages are not available to report.

How would the AWW be calculated?

[440.14\(1\)\(b\)](#) states that if the injured employee has not worked in such employment during substantially the whole of 13 weeks immediately preceding the accident, the wages of a similar employee in the same employment who has worked substantially the whole of such 13 weeks shall be used in making the determination under the preceding paragraph.

There are a few different ways to calculate the AWW and CR.

**Similar Employee:**

If the injured worker has not been working at the place of employment at least 13 weeks preceding the date of accident, the wages of a similar employee who has worked the whole of such 13 weeks shall be used in making the determination of the AWW for the injured worker.

*Gross total /weeks*  
 $\$6,825.00 /13 = \$525.00$  (AWW)

*Calculation of CR*  
 $AWW \times .6667$   
 $\$525.00 \times .6667 = \$350.02$

***\\$525.00 (AWW) and \\$350.02 (CR)***

**WAGE STATEMENT**  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**

RECEIVED BY CLAIMS-HANDLING ENTITY

**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**

EMPLOYEE NAME (First, Middle, Last) Injured Employee A		DATE OF ACCIDENT (Month-Day-Year) 03/16/2018
EMPLOYER NAME & ADDRESS Anderson Grocers 100 East Gaines Street Tallahassee, FL 32399		CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)
TELEPHONE (850) 867-5309		TELEPHONE
EMPLOYEE'S CUSTOMARY WORK WEEK Monday - Friday <small>(or Saturday thru Friday - Use 7 calendar day period)</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED PER WEEK 5 <small>(or 8 other hours)</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED PER WEEK 40 <small>(or 48 hours / week)</small>
ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		SIMILAR EMPLOYEE'S NAME Employee B
OCCUPATION OF SIMILAR EMPLOYEE Cashier		EMPLOYER'S CUSTOMARY WORK WEEK Saturday-Friday <small>(or Saturday thru Friday - Use 7 calendar day period)</small>

**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 PAYS) EMPLOYER COST ONLY	
WEEK NO.	FROM	TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY		HEALTH INSURANCE	RENT/ HOUSING
1	12/17/2017	12/21/2017	5	40	525.00			
2	12/24/2017	12/28/2017	5	40	525.00			
3	12/31/2017	01/04/2018	5	40	525.00			
4	01/07/2018	01/11/2018	5	40	525.00			
5	01/14/2018	01/18/2018	5	40	525.00			
6	01/21/2018	01/25/2018	5	40	525.00			
7	01/28/2018	02/01/2018	5	40	525.00			
8	02/04/2018	02/08/2018	5	40	525.00			
9	02/11/2018	02/15/2018	5	40	525.00			
10	02/18/2018	02/22/2018	5	40	525.00			
11	02/25/2018	03/01/2018	5	40	525.00			
12	03/04/2018	03/08/2018	5	40	525.00			
13	03/11/2018	03/15/2018	5	40	525.00			
**								

RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)

TOTAL: 6825.00

WILL EMPLOYER CONTRIBUTE TO PROVIDE ABOVE BENEFITS?  
 YES  NO  YES  NO

TOTAL FRINGE BENEFITS: \$ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES: \$ 6825.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW: 525.00 COMP RATE: 350.02

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.

PREPARED BY: NAME TELEPHONE # DATE

Form DFS-P2-DWC-1a (03/2009) Rule 69L-3.025, F.A.C.

**Rate of Pay/Contract of Hire:**

The Claim Administrator may use the rate of pay or actual wages of the injured worker by collecting the hourly rate the injured worker is paid and the number of hours they work on a weekly basis.

**Lost-Time Claim Scenario #4**

DOI: 3-16-18

Date Disability Began: 6-17-18

Waiting Week: 6-17- to 6-23-18

Employees hourly rate of pay : \$10

There is no similar employee.

Employment date: 03/10/18

*Hourly rate \$10.00*

*Work week: 40 hours*

*\$10.00 x 40= \$400.00 (AWW)*

*Calculation of CR*

*AWW x .6667*

*\$400.00 x .6667= \$ 266.68*

***\$400.00 (AWW) and \$266.68 (CR)***





## Concurrent Employment

If the injured worker has been working at an additional place of employment, then those wages are to be calculated into the wages from primary employment

The injured worker is responsible for providing the concurrent wages to the employer and/or the claims administrator for accurate calculation of the average weekly wage and compensation rate.

**WAGE STATEMENT**  
**FLORIDA DEPARTMENT OF FINANCIAL SERVICES**  
**DIVISION OF WORKERS' COMPENSATION**

RECEIVED BY CLAIMS-HANDLING ENTITY

**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

EMPLOYEE NAME (First, Middle, Last) Injured Employee A		DATE OF ACCIDENT (Month-Day-Year) 03/16/2006
EMPLOYER NAME & ADDRESS 111 Sesame Street Two Egg, FL 34509	CONCURRENT EMPLOYER NAME & ADDRESS (if applicable) Two Egg Cab Drivers 12345 Salad Lane Two Egg, FL 34509	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
TELEPHONE (850) 867-5309	TELEPHONE	SIMILAR EMPLOYEE'S NAME E.E. Employee
EMPLOYEE'S CUSTOMARY WORK WEEK Monday-Friday <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK 5 <small>(ex. 4 shift weeks)</small>	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK 40 <small>(ex. 40 hours / week)</small>
		OCCUPATION OF SIMILAR EMPLOYEE Administrative Assistant
		EMPLOYER'S CUSTOMARY WORK WEEK Monday-Friday <small>(ex. Saturday thru Friday - Use 7 calendar day period)</small>

**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.

WEEK NO.	WEEK		# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (Employee Paid)	
	FROM	TO					HEALTH INSURANCE	RENT/ HOUSING
1	03/20/2006	03/24/2006	5	20	225.00			
2	03/27/2006	03/31/2006	5	20	225.00			
3	04/03/2006	04/07/2006	5	20	225.00			
4	04/10/2006	04/14/2006	5	20	225.00			
5	04/17/2006	04/21/2006	5	20	225.00			
6	04/24/2006	04/28/2006	5	20	225.00			
7	05/01/2006	05/06/2006	5	20	225.00			
8	05/08/2006	05/12/2006	5	20	225.00			
9	05/15/2006	05/19/2006	5	20	225.00			
10	05/22/2006	05/26/2006	5	20	225.00			
11	05/29/2006	06/02/2006	5	20	225.00			
12	06/05/2006	06/09/2006	5	20	225.00			
13	06/12/2006	06/16/2006	5	20	225.00			
**								

RETURN THIS FORM TO:  
 (Claims-handling entity Name, Address & Telephone #)  
 ABC Insurance Company  
 111 Seabreeze Road  
 Orlando, FL 34512

TOTAL: 2925.00

WILL EMPLOYER CONTRIBUTE TO PROVIDE ABOVE BENEFITS?  
 YES  NO  YES  NO

TOTAL FRINGE BENEFITS: \$ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES: \$ 2925.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW: 225.00 COMP RATE: 150.01

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 69L-3.025, F.A.C.

## Benefit Calculators

In an effort to help stakeholders evaluate their benefit information, the Division provides a set of online benefit calculators on its web site.

The information and interactive calculators are made available to everyone as self-help tools for each person's independent use.

The Division cannot and does not guarantee their applicability or accuracy regarding each person's individual circumstances.

The Division offers three types of benefit calculators:

[Temporary Total Disability](#),

[Temporary Partial Disability](#), and

[Impairment Income](#)

If you have any questions about the calculation of benefits, or with estimating benefits, please contact the Bureau of Monitoring and Audit at (850) 413-1608.

The screenshot displays the official website of Jimmy Patronis, Florida's Chief Financial Officer, specifically the Division of Workers' Compensation. The page is titled "Benefit Calculators" and provides information on self-help tools for calculating benefits. It includes a navigation menu on the left with options like "DWC Search", "About the Division", and "Benefit Calculators". The main content area features a disclaimer and contact information for the Bureau of Employee Assistance and Ombudsman Office. Three calculator tools are highlighted: Temporary Total Disability Calculator, Temporary Partial Disability Calculator, and Impairment Income Calculator.

**JIMMY PATRONIS**  
FLORIDA'S CHIEF FINANCIAL OFFICER

CFO | NEWS | AGENCY | ESPAÑOL

DIVISION OF WORKERS' COMPENSATION

MYFLORIDACFO.COM > DIVISION > WC > EMPLOYEE > BENEFIT CALCULATORS

### Benefit Calculators

The information and interactive calculators are made available to you as self-help tools for your independent use. We can not and do not guarantee their applicability or accuracy in regards to your individual circumstances.

If you have any questions about the calculation of benefits, please contact the Bureau of Employee Assistance and Ombudsman Office at 1-800-342-1741 or [wceaanswer@myflorida.com](mailto:wceaanswer@myflorida.com).

- Temporary Total Disability Calculator
- Temporary Partial Disability Calculator
- Impairment Income Calculator

**QUICK LINKS**

- Proof of Coverage
- Exemption Information
- FAQs
- WC System Guide
- Coverage Assistance
- Benefit Calculators**
- DWC Event Calendar
- Report Suspected Non-Compliance
- Out-of-State Contractor Information

DEPARTMENT OF FINANCIAL SERVICES



CFO JIMMY PATRONIS