## Claim Cost Report

**Florida Department of Financial Services**  
**Division of Workers' Compensation**  
200 East Gaines Street  
Tallahassee, FL 32399-4226

**Complete all applicable sections before filing with the Division.**  
**Please print or type.**

<table>
<thead>
<tr>
<th>Social Security #</th>
<th>Employee Name: (First, Middle, Last)</th>
<th>Date of Accident: (Month-Day-Year)</th>
</tr>
</thead>
</table>

### Type of Report
- [ ] Initial Report summarizing first six months  
- [ ] Annual report on open case  
- [ ] Final report - case closed; no activity in past year or case settled

### Average Weekly Wage

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Weeks</th>
<th>Days</th>
<th>Paid to Date Column I (Do not round)</th>
<th>Type of Payment</th>
<th>Paid to Date Column II (Do not round)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Temporary Partial</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Medical</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Temporary Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>All DWC-90</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Temporary Total - 80%</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Transportation Medical APPTS.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Temporary Total - Training &amp; Education</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Drugs/Supplies All DWC-10</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Impairment Income Benefits
- Statutory Permanent Impairment (D/A's prior to 01/01/94)
- Wage Loss (D/A's prior to 01/01/94)

### Supplemental Income Benefits
- Permanent Total
- Permanent Total Supplemental

### Death
- Funeral
- Compensation Settlement Amount
- Third Party Recovery Amount
- Special Disability Trust Fund Recovery Amount
- All Other Recoveries Except Overpayments

### Insurer Code #

**Date Prepared:** (Month-Day-Year)  
**Insurer Name**

**Claims-Handling Entity Name, Address & Telephone**

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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.
DWC-13 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.