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, INSUANCE 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		HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION?
FROM	**TO**	☐ YES (IF YES, COMPLETE FORM, DATE & RETURN) ☐ 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? ☐ YES, (IF YES, COMPLETE INFORMATION BELOW) ☐ NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED FROM	PERIOD WORKED TO	TOTAL GROSS EARNINGS

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF-EMPLOYED? ☐ YES ☐ NO

BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED FROM	DATES SELF-EMPLOYED TO	WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED FROM	DATES SELF-EMPLOYED TO	WAGES, INCOME OR BENEFITS RECEIVED

V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? ☐ YES (IF YES, STATE AMOUNTS) ☐ 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. ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

PERIOD BENEFITS RECEIVED			TOTAL AMOUNT
SOURCES OF WAGES, INCOME OR BENEFITS	FROM	TO	

Any person, who knowingly and with intent ot 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	

LES Form DWC-19 (11/94)