PROOF OF CLAIM
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
OFFICE OF SPECIAL DISABILITY TRUST FUND
200 E. Gaines Street
Tallahassee, Florida 32399-4223

SDTF Claim Number	Date of Accident for which Reimbursement is claimed	Date of this claim
Name of Employee (address & phone number)		TT/Meds only (D/A after 12/31/92) [ ] Yes [ ] No
Name of Employer (address & phone number)		Evidence of $10,000 Threshold attached [ ] Yes [ ] No
Name of Carrier (address & phone number)		
Brief summary of Theory of Merger including pre-existing condition claimed and explanation of how it merged with instant accident to cause payment of excess permanent compensation. Check whether merger is: [ ] wage loss [ ] medical merger [ ] TT/Meds only D/A 1/1/94 or later		
Date of Maximum Medical Improvement:	Date of first payment of Permanent Benefits:	
Permanent Impairment Rating:	Amount of Permanent Benefits Paid:	
Please complete the attached Schedules and furnish appropriate documentation. Once a completed application is received, your claim will be filed and placed in line for review. Incomplete claims will not be placed in line.		

I hereby certify that I have made a good faith effort to enclose all pertinent materials requested.

SIGNATURE _____
(For Employer, Carrier, Servicing Agent, Attorney).

Mailing Address _____
(Street No) (City) (State) (Zip Code)

THE FOLLOWING DOCUMENTS ARE NECESSARY TO SUPPORT THIS CLAIM

Please TAB or divide the following scheduled documents and within each Schedule place each document in chronological order, beginning with the earliest date to the most recent.

SCHEDULE A - Evidence of Pre-existing condition. Attach medical reports documenting the pre-existing impairment or condition. Place in date order from first to last. (Do not include medical bills). Include any pertinent prior depositions.

SCHEDULE B - Details of accident for which reimbursement is claimed. Attach Notice of Injury (BCL-1) and attach medical records in date order from first to last. Be sure to include the report identifying the date of Maximum Medical Improvement and the permanency rating. (Do not include medical bills). Include any pertinent prior depositions.

SCHEDULE C - Attach sworn testimony that establishes the employer reached an informed conclusion, prior to the instant accident, that the pre-existing condition was a permanent impairment that was, or was likely to be, a hindrance or obstacle to employment. The sworn testimony should state specifics of how the employer reached the informed conclusion. If an affidavit is submitted, it must be an original.

SCHEDULE D

I. Attach signed copies of all court orders relevant to this claim.
II. Attach copies of the Notices of Action/Change Forms, (BCL-4's or DWC-4's) and Request for Wage Loss Forms (BCL-13b's or DWC-3's)
III. Attach the most recent Progress/Final Report Form (BCL-13 or DWC-13) showing all benefits paid.

SCHEDULE E - Attach copies of any Record on Appeal if relevant to this claim.