

NOTICE OF ACTION/CHANGE

DIVISION OF WORKERS' COMPENSATION

Attention: Information Management

200 East Gaines Street
Tallahassee, FL 32399-4226

For assistance call 1-800-342-1741 or contact your local EAO Office

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

SENT TO DIVISION DATE

DIVISION RECEIVED DATE

PLEASE PRINT OR TYPE

SOCIAL SECURITY NUMBER

EMPLOYEE NAME (First, Middle, Last)

DATE OF ACCIDENT (Month-Day-Year)

INDICATE ONLY ACTION OR CHANGE - PLEASE REFER TO KEY FOR DWC-4 TYPES/CODES ON REVERSE SIDE

ALL INDEMNITY SUSPENDED: EFFECTIVE DATE ____ - ____ - ____ REASON CODE: ____
INDEMNITY REINSTATED AFTER SUSPENSION: EFFECTIVE DATE ____ - ____ - ____ DISABILITY TYPE: ____

RELEASED TO RETURN TO WORK DATE: ____ - ____ - ____ RESTRICTIONS?: ☐ YES ☐ NO
ACTUAL RETURN TO WORK DATE: ____ - ____ - ____ RESTRICTIONS?: ☐ YES ☐ NO
DATE FINAL SETTLEMENT ORDER MAILED: ____ - ____ - ____
OVERALL MMI DATE: ____ - ____ - ____ PI RATING: ____ % BAW DATE OF DEATH ____ - ____ - ____

PERMANENT IMPAIRMENT BENEFITS (D/A'S PRIOR TO 01/01/94): DATE PAID: ____ - ____ - ____
IMPAIRMENT INCOME BENEFITS (D/A'S ON OR AFTER 01/01/94): START DATE: ____ - ____ - ____ WEEKLY RATE: \$ ____
TOTAL NUMBER OF WEEKS OF ENTITLEMENT: ____

PERMANENT TOTAL: DATE ACCEPTED/ADJUDICATED ____ - ____ - ____
WEEKLY PT SUPPLEMENTAL RATE \$ ____
WEEKLY PT SUPP EFFECTIVE DATE ____ - ____ - ____
AVERAGE WEEKLY WAGE AND/OR COMPENSATION RATE AMENDMENTS:
PREVIOUS AWW: \$ ____
PREVIOUS COMP RATE: \$ ____

BENEFIT ADJUSTMENTS

| BENEFIT ADJUSTMENT CODE | BENEFIT ADJUSTMENT CODE | AMENDED AWW: |
|--------------------------|--------------------------|--|
| DISABILITY TYPE ADJUSTED | DISABILITY TYPE ADJUSTED | \$ ____ |
| WEEKLY ADJ AMOUNT \$ | WEEKLY ADJ AMOUNT \$ | \$ ____ |
| EFFECTIVE DATE | EFFECTIVE DATE | RETROACTIVE TO D/A: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| ADJUSTMENT END DATE | ADJUSTMENT END DATE | IF NO, GIVE EFFECTIVE DATE: ____ - ____ - ____ |

CORRECTIONS OF:
☐ SOCIAL SECURITY NUMBER/CORRECT #: ____
☐ DATE OF ACCIDENT/CORRECT DATE: ____ - ____ - ____
☐ EMPLOYEE'S NAME/CORRECT NAME: ____
☐ CLAIMS-HANDLING ENTITY: ____
CLASS CODE
NAICS CODE

REMARKS:

| | |
|-----------------------|---|
| CC: | INSURER NAME |
| INSURER CODE # | DATE PREPARED: (Month-Day-Year) ____ - ____ - ____ |
| SERVICE CO/TPA CODE # | CLAIMS-HANDLING ENTITY FILE # |

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.

KEY FOR DFS-F2-DWC-4 TYPES / CODES

DISABILITY TYPES:

| | | |
|-----|---|--|
| TT | - | Temporary Total Disability Benefits |
| TTC | - | Temporary Total Disability Benefits at 80% for severe injuries per Section 440.15(2)(b), FS. |
| TTE | - | Temporary Total Benefits while in an approved training and education program |
| TP | - | Temporary Partial Disability Benefits |
| PI | - | Permanent Impairment Benefits (Dates of Accident from 08/01/79 through 12/31/93) |
| IB | - | Impairment Income Benefits (Dates of Accident on or after 01/01/94) |
| WL | - | Wage Loss Benefits (Dates of Accident from 08/01/79 through 12/31/93) |
| SB | - | Supplemental Benefits (Dates of Accident on or after 01/01/94) |
| PT | - | Permanent Total Disability Benefits |
| DB | - | Death Benefits |

SUSPENSION REASON CODES:

(All Indemnity Benefits have been suspended because:)

| | | |
|----|---|--|
| S1 | - | The employee returned to work, or was medically released to return to work |
| S2 | - | The employee did not comply with medical treatment requirements in the Workers' Compensation Law / Rules |
| S3 | - | The employee did not comply with administrative requirements in the Workers' Compensation Law / Rules |
| S4 | - | The employee died |
| S5 | - | The employee became incarcerated in a public institution |
| S6 | - | The employee's whereabouts are unknown |
| S7 | - | The employee's benefits have been used up or entitlement to those benefits has ended |
| S8 | - | The employee's claim has been changed to another jurisdiction |

BENEFIT ADJUSTMENT CODES:

(The employee's rate of pay is being reduced or adjusted because of:)

| | | |
|---|---|--|
| A | - | Apportionment / Contribution from another insurer |
| B | - | Subrogation / Third Party Recovery |
| C | - | Overpayment of Benefits from the insurer |
| H | - | Child Support Payment |
| N | - | Employee not complying with Medical or Training and Education requirements |
| P | - | Carrier taking credit for an advance given to the employee |
| R | - | Social Security Retirement Benefits received by the employee |
| S | - | Social Security Disability Benefits received by the employee |
| U | - | Unemployment Compensation Benefits received by the employee |
| V | - | A Safety Violation by the employee |
| X | - | A change in the dependents entitled to Death Benefits |

DWC-4 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.