DEPARTMENT OF FINANCIAL SERVICES
Division of Workers' Compensation

Work-based Learning (WBL) Program Workers' Compensation Premium Reimbursement Application

WBL Program Employer Details

Employer Name: _____ Employer FEIN: _____

Employer Contact Name & Title: _____

Employer Phone: _____ Employer Email: _____

Employer Address: _____

_____

Workers' Comp Insurer Name: _____ Policy #: _____

Description of Business: _____

WBL Program Educational Institution Details

Name of Educational Institution	Instructor Name	Instructor Phone	Instructor Email

WBL Program Student Details

Full Student Name	Age at time of WBL Participation	Name of Instructor	WBL Start Date	WBL End Date

Reimbursement Application Details

Total number of students participating in WBL opportunities with the EMPLOYER: _____

Number of students participating in PAID WBL opportunities: _____

Number of students participating in UNPAID WBL opportunities: _____

☐ As the employer representative, we choose to accept the Department's calculation method to determine the proportionate share of the cost of workers' compensation premium attributable to WBL students. The Department's method utilizes the Florida Office of Insurance Regulation's only approved premium calculation methodology for all Florida workers' compensation insurers. If you accept this method, the Department will calculate each student's premium using their NCCI Classification Code, the corresponding rate and payroll/100. We understand that the premium reimbursement period is Fiscal Year July 2024 – June 2025.

☐ As the employer representative, we choose to provide our own method to determine the proportionate share of the cost of workers' compensation premium attributable to WBL students. We understand that the premium reimbursement period is Fiscal Year July 2024 – June 2025. We must submit all necessary documentation to support the described method used to determine the proportionate share of the cost of workers' compensation premium in the box provided below.

If you have chosen to provide your own calculation method, please provide the Fiscal Year July 2024 – June 2025 requested premium reimbursement amount: _____

Note that reimbursement may only be sought for the number of students who were considered PAID EMPLOYEES.

Employer Attestations and Statements

Choose **ONE** of the following.

☐ As a PRIVATE EMPLOYER, I swear and confirm that I am seeking reimbursement for the proportionate cost of workers' compensation premium related to WBL students only.

☐ As a SCHOOL DISTRICT or FLORIDA COLLEGE SYSTEM institution that is considered the employer, I swear and confirm that I am seeking reimbursement for the proportionate cost of workers' compensation premium related to WBL students only.

Initial each of the following statements below in accordance with s. 446.54, F.S.

☐ I swear and confirm that each student that is part of this reimbursement application was 18 years of age or younger during the time of participation in the WBL program.

☐ I agree that the EMPLOYER will maintain documentation supporting the information in the application for 5 years.

Initial the following statement.

☐ I acknowledge that any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approval is liable to the state for a civil penalty of not less than $5,500 and not more than $11,000 and for treble the amount of damages the state sustains because of the act of that person per s. 68.082, F.S.

Printed Name of Person Authorized to Submit this Application: _____

Signature of Authorized Person: _____

Date: _____

Required Documentation Needed to Process Reimbursement Application

- ☐ I have attached a copy of the Work-based Learning Training Agreement & Plan for each student listed in this application.
- ☐ I authorize the Florida Department of Financial Services to utilize the Department of Revenue Reemployment Tax Information for the prior two-year period as a part of my business records for payroll validation purposes.
- ☐ I understand to be reimbursed, that the EMPLOYER must register with MyFloridaMarketplace as a vendor for the State of Florida.

Printed Name of Person Authorized to Submit this Application: _____

Signature of Authorized Person: _____

Date: _____

Completed applications should be sent to the following address:
Florida Department of Financial Services
Division of Workers' Compensation
200 East Gaines Street
Tallahassee, FL 32399-4223