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 _____ - _____ - _____

BENEFIT ADJUSTMENTS

BENEFIT ADJUSTMENT CODE	_____	BENEFIT ADJUSTMENT CODE	_____
DISABILITY TYPE ADJUSTED	_____	DISABILITY TYPE ADJUSTED	_____
WEEKLY ADJ AMOUNT $	_____	WEEKLY ADJ AMOUNT $	_____
EFFECTIVE DATE	_____	EFFECTIVE DATE	_____
ADJUSTMENT END DATE	_____	ADJUSTMENT END DATE	_____

AVERAGE WEEKLY WAGE AND/OR COMPENSATION RATE AMENDMENTS:

PREVIOUS AWW: $ _____

PREVIOUS COMP RATE: $ _____

AMENDED AWW: $ _____

AMENDED COMP RATE: $ _____

RETROACTIVE TO D/A: ☐ YES ☐ NO

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) _____ - _____ - _____

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

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.

Form DFS-F2-DWC-4 (03/2009) Rule 69L-3.025, F.A.C.

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' 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.