

WAGE STATEMENT

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY DIVISION OF WORKERS' COMPENSATION

FOR CARRIER'S DATE STAMP

REC'D BY CARRIER

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or insurance carrier. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

| | | | |
|--|--|--|---|
| EMPLOYEE NAME | | SOCIAL SECURITY NUMBER | DATE OF ACCIDENT (mm/dd/yyyy) |
| EMPLOYER NAME & ADDRESS: Street: _____ City: _____ State: _____ Zip: _____ | | CONCURRENT EMPLOYER NAME & ADDRESS (if applicable): Street: _____ City: _____ State: _____ Zip: _____ | ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? YES NO |
| TELEPHONE | | TELEPHONE | SIMILAR EMPLOYEE'S NAME: |
| EMPLOYEE'S CUSTOMARY WORK WEEK: <small>(ex. Saturday thru Friday – Use 7 calendar day period)</small> | | EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK: <small>(ex. 5 days / week)</small> | SSN OF SIMILAR EMPLOYEE |
| | | EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK: <small>(ex. 40 hours / week)</small> | OCCUPATION OF SIMILAR EMPLOYEE |
| <p>NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your carrier within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your carrier within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.</p> | | | |

Please list wages earned for the 91 day period immediately preceding the accident. DO NOT combine wages of two or more employees.

| WEEK NO. | WEEK | | # OF DAYS WORKED THAT WEEK | # HOURS WORKED THAT WEEK | GROSS PAY | GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME | FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY | |
|----------|------|----|----------------------------|--------------------------|-----------|---|---|---------------|
| | FROM | TO | | | | | HEALTH INSURANCE | RENT/ HOUSING |
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|--|-------|--|-----------------------------|--|---|
| RETURN THIS FORM TO: (Carrier Name, Address & Telephone#) <div style="text-align: center;"> FHM Insurance Company Served By: UNITED SELF INSURED SERVICES P.O. Box 616648, Orlando, FL 32861-6648 407-351-1212 888-346-3461 </div> | TOTAL | | TOTAL FRINGE BENEFITS \$ | TOTAL OF GROSS PAY, GRATUITIES AND FRINGES \$ | WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? YES NO YES NO |
| (FOR CARRIER USE ONLY) | | | | | |
| | | | | AWW | COMP RATE |

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, is guilty of a felony of the third degree.

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| PREPARER'S NAME | TELEPHONE | DATE (mm/dd/yyyy) |
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