



# Work Comp Associates, Inc.

*Florida's Premier Source for Workers' Compensation Coverage & Information*

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## **Request for Wage Loss/Temporary Partial Benefits**

DWC-3

Revision date: 6/19/2007

Instructions to follow.

This form is provided courtesy of Work Comp Associates, Inc.

Mailing Address: P.O. Box 33297, Palm Beach Gardens, FL 33420-3297  
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**FLORIDA DEPARTMENT OF FINANCIAL SERVICES  
DIVISION OF WORKERS' COMPENSATION**

**REQUEST FOR WAGE LOSS/TEMPORARY PARTIAL BENEFITS**

1-800-342-1741 or contact your local office for assistance

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

RECEIVED BY CLAIMS-HANDLING ENTITY	SENT TO DIVISION DATE	DIVISION RECEIVED DATE

EMPLOYEE NAME (First, Middle, Last) & ADDRESS	EMPLOYER NAME & ADDRESS	SOCIAL SECURITY #
TELEPHONE:	TELEPHONE:	DATE OF ACCIDENT: (Month-Day-Year)

**EMPLOYEE: You must complete one of these forms every two weeks. Complete and sign this section and submit to the claims-handling entity (adjuster) handling your claim.**

ARE YOU RECEIVING SOCIAL SECURITY?  YES  NO IF YES, AMOUNT \$ \_\_\_\_\_

ARE YOU RECEIVING UNEMPLOYMENT COMPENSATION?  YES  NO IF YES, AMOUNT \$ \_\_\_\_\_

I CLAIM LOSS OF WAGES FOR TWO WEEKS AS FOLLOWS Week One \_\_\_\_/\_\_\_\_/\_\_\_\_ Week Two \_\_\_\_/\_\_\_\_/\_\_\_\_

I WAS EMPLOYED DURING THIS TWO WEEK PERIOD AS FOLLOWS: (Attach check stub or other documentation.)

EMPLOYER NAME & ADDRESS \_\_\_\_\_

EMPLOYER TELEPHONE (\_\_\_\_) \_\_\_\_\_

Gross Wages: Week One \$ \_\_\_\_\_ Week Two \$ \_\_\_\_\_

I WAS NOT EMPLOYED AND LOOKED FOR EMPLOYMENT AS DOCUMENTED ON THE BACK OF THIS FORM.

Upon making this claim and signing this document, I hereby authorize the release of Unemployment Compensation wage and benefit information and I hereby authorize the release of Social Security information. I declare that the facts reported herein are true to the best of my knowledge and I understand that any false or misleading statement I make could subject me to prosecution for fraud pursuant to Section 440.1051(3), Florida Statutes.

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.

EMPLOYEE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

CLAIMS-HANLDING ENTITY: Compute wage loss and complete other areas. Send employee copy with payment check and additional forms. Forward copy to employer (at time of injury) and to Division (upon request).

WAGE LOSS: MMI Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Rating \_\_\_\_\_%  TEMPORARY PARTIAL  CONTROVERTED - DWC-12 Attached

WEEKS ONE: ____/____/____ to ____/____/____	WEEK TWO: ____/____/____ to ____/____/____		
AWW-BEFORE INJURY (Use applicable rate) _____ x _____	ADJ. WW	AWW-BEFORE INJURY (Use applicable rate) _____ x _____	ADJ. WW
TOTAL GROSS EARNINGS		TOTAL GROSS EARNINGS	
Discount Factor Applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Deemed earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	-	Discount Factor Applied? <input type="checkbox"/> Yes <input type="checkbox"/> No Deemed earnings <input type="checkbox"/> Yes <input type="checkbox"/> No	-
TOTAL WAGE LOSS	=	TOTAL WAGE LOSS	=
MULTIPLY BY APPLICABLE RATE	x	MULTIPLY BY APPLICABLE RATE	x
WAGE LOSS BENEFITS	=	WAGE LOSS BENEFITS	=
OFFSET (Identify benefits)	-	OFFSET (Identify benefits)	-
AMOUNT DUE/PAID	=	AMOUNT DUE/PAID	=

TOTAL AMOUNT PAID \$ \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

ADJUSTER NAME:  DATE: ____/____/____	INSURER NAME:  CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE:
ADJUSTER SIGNATURE:	

