



Work Comp Associates, Inc.

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

Employee Earnings Report

DWC-19

Revision date: 6/19/2007

Instructions:

Please complete the form starting with the section "PLEASE PRINT OR TYPE."

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

EMPLOYEE EARNINGS REPORT
FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

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

CAUTION

FAILURE OR REFUSAL OF EMPLOYEE TO COMPLETE, SIGN, AND RETURN THIS REPORT WITHIN 21 DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST MAY CAUSE PAYMENT OF BENEFITS TO STOP UNTIL SUCH TIME AS THE COMPLETED FORM IS FURNISHED TO THE REQUESTING PARTY.

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

EMPLOYEE'S SOCIAL SECURITY NUMBER <u> </u>	EMPLOYEE'S NAME (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
EMPLOYEE'S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CLAIMS-HANDLING ENTITY NAME & ADDRESS

II. NOTICE TO EMPLOYEE

THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.

TIME PERIOD TO BE REPORTED FROM _____ TO _____	HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION? <input type="checkbox"/> YES (IF YES, COMPLETE FORM, SIGN, DATE, & RETURN) <input type="checkbox"/> NO (IF NO, SIGN, DATE AND RETURN)
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IF NECESSARY, ATTACH ADDITIONAL EARNINGS DOCUMENTATION

III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II? YES (IF YES, COMPLETE INFORMATION BELOW)
 NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED		TOTAL GROSS EARNINGS
		FROM	TO	

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF-EMPLOYED? YES NO BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED
FROM	TO		FROM	TO	

V. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? YES (IF YES, STATE AMOUNTS)
 NO

TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS

VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another insurer, etc? Attach additional documentation if necessary. YES (IF YES, STATE AMOUNTS)
 NO

SOURCE OF WAGES, INCOME OR BENEFITS	PERIOD BENEFITS RECEIVED		TOTAL AMOUNT
	FROM	TO	

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.

I HAVE REVIEWED, UNDERSTAND, AND ACKNOWLEDGE THE ABOVE. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

VII. RETURN TO (To be completed by requesting party):

REQUESTING PARTY'S NAME	REQUESTING PARTY'S SIGNATURE	REQUESTING PARTY'S ADDRESS & TELEPHONE
TITLE	DATE: (Month-Day-Year)	