FIRST REPORT OF INJURY OR ILLNESS

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

For assistance call 1-800-342-1741
or contact your local EAO Office
Report all deaths within 24 hours 1-800-219-8953 or (850) 922-8953

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

PLEASE PRINT OF TYPE — **EMPLOYEE INFORMATION**

NAME (First, Middle, Last)	Social Security Number	Date of Accident (Month-Day-Year)	Time of Accident [ ] AM [ ] PM

HOME ADDRESS Street/Apt #: City: State: Zip: TELEPHONE Area Code Number	EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION	DATE OF BIRTH	SEX [ ] M [ ] F	INJURY THAT OCCURRED	PART OF BODY AFFECTED

EMPLOYER INFORMATION

COMPANY NAME: D. B. A.: Street: City: State: FL Zip: TELEPHONE Area Code (305) Number 595-3323	FEDERAL I.D. NUMBER (FEIN) NATURE OF BUSINESS DATE EMPLOYED LAST DATE EMPLOYEE WORKED RETURNED TO WORK [ ] YES [ ] NO IF YES, GIVE DATE	DATE FIRST REPORTED (Month/Day/Year) POLICY/MEMBER NUMBER PAID FOR DATE OF INJURY [ ] YES [ ] NO WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? [ ] YES LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP?

EMPLOYER'S LOCATION ADDRESS (If different) Street: City: State: Zip: LOCATION # (If applicable)	DATE OF DEATH (If applicable) AGREE WITH DESCRIPTION OF ACCIDENT? [ ] YES [ ] NO	RATE OF PAY [ ] HR [ ] WK $ PER [ ] DAY [ ] MO Number of hours per day Number of hours per week Number of days per week

PLACE OF ACCIDENT (Street, City, State, Zip) Street: City: State: Zip: COUNTY OF ACCIDENT	

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 statement.

_____ EMPLOYEE SIGNATURE (If available to sign)
_____ DATE
_____ EMPLOYER SIGNATURE
_____ DATE

NAME, ADDRESS AND TELPHONE OF PHYSICIAN OR HOSPITAL

TEL:

AUTHORIZED BY EMPLOYER [ ] YES [ ] NO

CLAIMS-HANDLING ENTITY INFORMATION

[ ] 1(a) Denied Case – DWC-12, Notice of Denial Attached

[ ] 1(b) Indemnity Only Denied Case – DWC-12, Notice of Denial Attached

[ ] 2. Medical Only which became Lost Time Case (Complete all required information in #3)
Employee's 8th Day of Disability
Entity's Knowledge of 8th Day of Disability

[ ] 3. Lost time Case – 1st day of disability
Full Salary in lieu of comp? [ ] YES Full Salary End Date

Date First Payment Mailed AWW Comp Rate

[ ] T.T. [ ] T.T. – 80% [ ] T.P. [ ] I.B. [ ] P.T. [ ] DEATH [ ] SETTLEMENT ONLY

Penalty Amount Paid in 1st Payment $ Interest Amount Paid in 1st Payment $

REMARKS:

INSURER CODE #	EMPLOYEE'S CLASS CODE	EMPLOYER'S NAICS CODE
1152		
SERVICE CO/TPA CODE #	**CLAIMS-HANDLING ENTITY** FILE #	
6257	WCFL	

INSURER NAME
Ascendant Commercial Insurance, Inc.

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE

Ascendant Claims Services, LLC
P.O. Box 141739 Coral Gables, FL 33114
Customer Service: 877-834-4991
FNOI Only: 877-834-4993