## 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

INJURY THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH

SEX [ ] M [ ] F

**EMPLOYER INFORMATION**

COMPANY NAME:
D. B. A.:
Street:
City: State: FL Zip:

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

TELEPHONE Area Code (305) Number 595-3323

DATE EMPLOYED

PAID FOR DATE OF INJURY [ ] YES [ ] NO

EMPLOYER'S LOCATION ADDRESS (If different)
Street:
City: State: Zip:
LOCATION # (If applicable)

LAST DATE EMPLOYEE WORKED

RETURNED TO WORK [ ] YES [ ] NO
IF YES, GIVE DATE

WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? [ ] YES

LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP?

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

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

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 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

**INSURER** CODE #
1152

EMPLOYEE'S CLASS CODE

EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE #
6257

**CLAIMS-HANDLING ENTITY** FILE #
WCFL