

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 OR 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: _____ ST _____ FL _____ Zip: _____		EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include cause of injury)		
TELEPHONE _____ Area Code _____ Number _____				
OCCUPATION		INJURY/ILLNESS THAT OCCURRED	PART OF BODY AFFECTED	
DATE OF BIRTH	SEX M <input type="checkbox"/> F <input type="checkbox"/>			

EMPLOYER INFORMATION

COMPANY NAME: Omega Business Solutions, INC	FEDERAL I.D. NUMBER (FEIN) 59-3537052	DATE FIRST REPORTED (Month/Day/Year)
DBA: _____	NATURE OF BUSINESS PEO	POLICY/MEMBER NUMBER SUA Policy#WLSLTHPE 000095-01
Street: 199 Ave K, S. E.		
City: Winter Haven State: FL Zip: 33880	DATE EMPLOYED	PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO
TELEPHONE _____ Area Code _____ Number 863-299-0872	LAST DATE EMPLOYEE WORKED	WILL YOU CONTINUE TO PAY WAGES INSTEAD OF WORKERS' COMP? <input type="checkbox"/> YES
EMPLOYER'S LOCATION ADDRESS (if different) Street: _____ City: _____ State: FL Zip: _____	RETURNED TO WORK <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST DAY WAGES WILL BE PAID INSTEAD OF WORKERS' COMP ___/___/___
PHONE NUMBER _____	IF YES, GIVE DATE	RATE OF PAY _____ X HR <input type="checkbox"/> WK
LOCATION # (If applicable)		\$ _____ PER <input type="checkbox"/> DAY <input type="checkbox"/> MO
PLACE OF ACCIDENT (Street, City, State, Zip) Street: _____ City: _____ State: FL Zip: _____	DATE OF DEATH (if applicable) ___/___/___	Number of hours per day Number of hours per week Number of days per week
COUNTY OF ACCIDENT:	AGREE WITH DESCRIPTION OF ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	NAME, ADDRESS AND TELEPHONE OF PHYSICIAN OR HOSPITAL
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 _____	AUTHORIZED BY EMPLOYER <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER SIGNATURE _____	DATE _____	

CLAIMS-HANDLING ENTITY INFORMATION

<input type="checkbox"/> 1(a) Denied Case - DWC-12, Notice of Denial Attached	<input type="checkbox"/> 2. Medical Only which became Lost Time Case (Complete all required info in #3)
<input type="checkbox"/> 1(b) Indemnity Only Denied Case – DWC-12, Notice of Denial Attached	Employee's 8 th Day of Disability ___/___/___
	Entity's Knowledge of 8 th Day of Disability ___/___/___
<input type="checkbox"/> 3. Lost Time Case – 1 st day of disability ___/___/___	Full Salary in lieu of comp? <input type="checkbox"/> YES <input type="checkbox"/> NO Full Salary End Date ___/___/___
Date First Payment Mailed ___/___/___ AWW _____ Comp Rate _____	
<input type="checkbox"/> T.T. <input type="checkbox"/> T.T. – 80% <input type="checkbox"/> T.P. <input type="checkbox"/> I.B. <input type="checkbox"/> P.T. <input type="checkbox"/> Death <input type="checkbox"/> SETTLEMENT ONLY	
Penalty Amount Paid in 1 st Payment \$ _____ Interest Amount Paid in 1 st Payment \$ _____	

REMARKS:	INSURER NAME SUA Insurance Company
INSURER CODE # 1024	CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE Unisource Administrators, Inc. PO Box 22802 Sarasota FL 34276 1-877-340-1924
SERVICE CO/TPA CODE # 6173	EMPLOYEE'S CLASS CODE
	EMPLOYER'S NAICS CODE
	CLAIMS-HANDLING ENTITY FILE #

