PERMANENT TOTAL OFF-SET WORKSHEET

SENT TO DIVISION DATE	DIVISION RECEIVED DATE

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION
200 East Gaines Street
TALLAHASSEE, FLORIDA 32399-4224

SOCIAL SECURITY #:	EMPLOYEE NAME: (First, Middle, Last)	DATE OF ACCIDENT: (Month-Day-Year)
DATE OF BIRTH: (Month-Day-Year)	EMPLOYER NAME:	DATE ACCEPTED/ADJUDICATED PT: (Month-Day-Year)

FORMULA:

1. Convert monthly benefits to weekly benefits by dividing the monthly amount by 4.3.
2. Add Compensation Rate + Primary Insurance Amount (PIA) or the Maximum Family Benefits (MFB) if the employee has dependents.
3. Add five percent (5%) permanent total supplemental benefits for dates of accident prior to October 1, 2003. For dates of accident on or after October 1, 2003, add three percent (3%) permanent total supplemental benefits. Use Weekly Supplemental Rate at time of PT acceptance.
4. Subtract the greater of 80% Average Weekly Wage (AWW) or 80% Weekly Average Current Earnings (ACE).
5. Resulting difference is the offset amount (which shall not exceed the Initial Social Security Benefit).

BENEFITS INFORMATION (Monthly/Weekly)

Weekly Compensation	_____		
Average Weekly Wage	_____	multiplied by .80 = 80% AWW	_____
Monthly PIA	_____	divided by 4.3 = Weekly PIA	_____
Monthly ACE	_____	divided by 4.3 = Weekly ACE	_____
Maximum Family Benefit	_____	divided by 4.3 = Weekly MFB	_____

Offset Calculation

	_____	Weekly Compensation (or applicable Maximum rate)
[+]	_____	Weekly PIA or MFB (whichever is applicable)
[+]	_____	5% PT Supplemental (**3% for injuries occurring on or after October 1, 2003)**
[=]	_____	Combined Weekly Benefits
[-]	_____	Greater of 80% AWW or 80% Weekly ACE
[a]	_____	Total Offset Available (shall not exceed applicable PIA or MFB) weekly compensation
[b]	_____	Offset Against Supplements (Division paid claims only)
[c]	_____	Offset Against Compensation
[d]	_____	Total Benefits Payable After Offset (Comp Rate-c=d)

Effective _____ the Division / Claims-handling entity in accordance with Section 440.15(9) F.S., will begin applying the Social Security Offset to this case.

Please attach a copy of the completed Form DFS-F2-DWC-14, Request for Social Security Disability Benefit Information and Form DFS-F2-DWC-4, Notice of Action/Change, as required by Rule 69L-3.0091, 69L-3.0194 and 69L-3.01945, F.A.C.

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.

INSURER CODE #	ADJUSTER NAME	INSURER NAME: CLAIMS-HANDLING ENTITY NAME, ADDRESS AND TELEPHONE
SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	

DWC-33 Purpose and Use Statement

The collection of the social security number on this form is imperative for the Division of Workers' Compensation's performance of its duties and responsibilities as prescribed by law. The social security number will be used as a unique identifier in Division of Workers' Compensation database systems for individuals who have claimed benefits under Chapter 440, Florida Statutes. It will also be used to identify information and documents in those database systems regarding individuals who have claimed benefits under Chapter 440, Florida Statutes, for internal agency tracking purposes and for purposes of responding to both public records requests and subpoenas that require production of specified documents. The social security number may also be used for any other purpose specifically required or authorized by state or federal law.