STATEMENT OF QUARTERLY EARNINGS

FOR SUPPLEMENTAL INCOME BENEFITS

DATES OF ACCIDENT ON OR AFTER JANUARY 1, 1984 THROUGH SEPTEMBER 30, 2003

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

1-800-342-1741 or contact your local office for assistance

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

PLEASE PRINT OR TYPE

A

SOCIAL SECURITY NUMBER	EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT:Month-Day-Year)
ACCIDENT EMPLOYER NAME	FILING PERIOD: ______________ THROUGH ______________ (BEGINNING DATE / ENDING DATE)	

B

NOTICE TO EMPLOYEE: Report all wages earned during the filing period in the area provided below.

PLEASE CHECK APPROPRIATE BOXES: *** **See instructions on the back side of this form** ***

☐ I RETURNED TO WORK BUT MY REDUCED WAGES WERE A DIRECT RESULT OF MY IMPAIRMENT FROM THIS INJURY.

☐ DURING ANY WEEKS I WAS NOT EMPLOYED, I HAVE IN GOOD FAITH ATTEMPTED TO OBTAIN EMPLOYMENT, WHICH I AM ABLE TO DO.

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 THAT THE INFORMATION PROVIDED ON THIS FORM AND ANY ATTACHMENTS IS TRUE AND CORRECT.

EMPLOYEE SIGNATURE: ______________________________ DATE: ______________

C

CURRENT RATE OF PAY: $____________PER ☐ HR ☐ WK ☐ DAY ☐ MO

HOURS PER DAY __________ HOURS PER WEEK__________ DAYS PER WEEK __________

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# OF HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	(CLAIMS-HANDLING ENTITY USE ONLY) DEEMED WAGES	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: HEALTH INSURANCE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: RENT/ HOUSING
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									

AREA BELOW FOR CLAIMS-HANDLING ENTITY USE ONLY

TOTALS:	1	2	3	4	5

D

MONTHLY SUPP. BENEFITS CALCULATION	
Pre-injury AWW x 4.3 x 0.80 =	Adjusted Monthly Wage $
Minus (Current AWW x 4.3) =	Current Monthly Wage $
Equals Total Monthly Wage Loss	$
Multiplied by 0.80 =	Monthly S.I.B. Payable $
Payment Period ______/______/______ thru ______/______/______	
Subject to Maximum Payable at Comp Rate __________ x 4.3	$
Payment Amount for Initial Month	$

BENEFIT ADJUSTMENT DUE TO OVERPAYMENT	
Amount Paid for ____/____/____ thru ____/____/____ Paid on ______/______/______	$
Amount Due for ____/____/____ thru ____/____/____	$
Total Amount of Overpayment Credit	$
Amount of Overpayment Credit applied per month (Not to EXCEED 20% of Monthly Payment)	$
Monthly Adjusted Amount due for ______/______/______ thru ______/______/______	$
Remaining Overpayment Credit	$
ADJUSTER NAME:	

TOTAL OF 1+2+3+4+5	$
EQUALS	DIVIDE BY # OF WEEKS IN FILING PERIOD
CURRENT AVERAGE WEEKLY WAGE	$

☐ Payment for filing period denied. See attached Notice of Denial.

INSURER CODE #	DATE PREPARED	RETURN THIS FORM TO: CLAIMS-HANDLING ENTITY NAME, ADDRESS AND TELEPHONE#
SERVICE CO/TPA CODE #	CLAIMS-HANDLING ENTITY FILE #	

STATEMENT OF QUARTERLY EARNINGS FOR SUPPLEMENTAL INCOME BENEFITS

SOCIAL SECURITY NUMBER	EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT: Month-Day-Year)

INSTRUCTIONS:

(1) Fill out Sections B and C on the front of this form.
Use the form that has the first two lines on the front of the form with your name, etc. already completed. List any money you earned during the 13 weeks for the filing period shown on the second line.

(2) Attach copies of paycheck stubs, statements from your employer(s), or any other documentation you may have of your earnings during the filing period.

(3) If you have no earnings in a particular week, put down $0 for that week.

(4) In the boxes below, list all employers you may worked for during the filing period, and the addresses, phone numbers and dates you were employed.

(5) Sign and send the completed form to the Insurer or Claims-handling entity name and address noted in the lower right-hand corner on the front of this form.

(6) Section 440.15(2), Florida Statutes, requires you to return this form in a timely manner and the failure to return this form may result in a delay in the payment of benefits.

A Form DFS-F2-DWC-40, Statement of Quarterly Earnings for Supplemental Income Benefits, must be submitted at the end of every three months in order to receive these benefits.

NAME OF EMPLOYER(S) DURING THIS FILING PERIOD

Employer Name	Employer Address	Employer Phone	Date(s) Employed

DWC-40 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.