DEPARTMENT OF FINANCIAL SERVICES

MODULE: AVERAGE WEEKLY WAGE CALCULATION

Division of Workers' Compensation

Bureau of Monitoring and Audit

AVERAGE WEEKLY WAGE (AWW)

s. 440.14, F.S., Rule 69L-3.30046, F.A.C.

Average Weekly Wage (AWW)

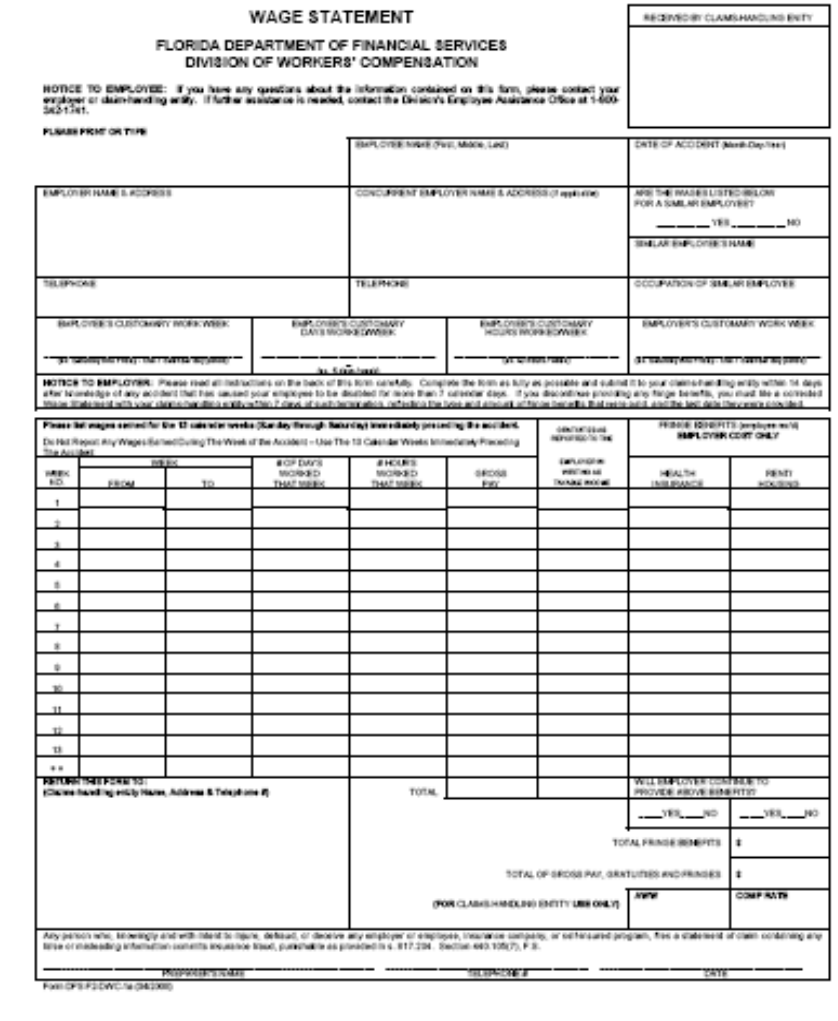
- The amount of money the injured worker (IW) earns each week
- It is the basis for all monetary benefits being paid to the injured worker
- It is the single most important factor in the value of the workers' compensation claim

Wage Statement

- The employer reports all required wage information of the injured worker on the DFS-F2-DWC-1a form to the claim administrator within 14 days of the employer's knowledge of a Lost-Time or a medical to Lost-Time case
- The whole of 13 weeks of the injured worker's wages immediately preceding the date of accident are used to calculate AWW
- If 13 weeks of the injured worker's wages are not available, then at least 75% of the total customary hours of employment which equates to 9.75 weeks (10 weeks can be utilized)

AWW (continued)

- If the injured worker has not worked in such employment during substantially the whole of 13 weeks immediately preceding the accident, the wages of a similar employee in the same employment can be used
- If the injured worker is a seasonal worker and the prior methods cannot fairly be applied in determining the AWW, the employer may use the calendar year or the 52 weeks immediately preceding the accident.
- If any of the prior methods cannot reasonably and fairly be applied, the full-time weekly wages of the injured worker can be used
- An interactive DFS-F2-DWC-1a can be found on the Division's website.



WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

Lost-Time Claim Scenario #1

DOI: 3-16-18

Date Disability Began: 6-17-18

Waiting Week: 6-17- to 6-23-18

Employer wage statement provided includes 13 weeks of earnings preceding the accident = $6,825.

What is the AWW?

Gross total /weeks

$6,825/13= $525.00 (AWW)

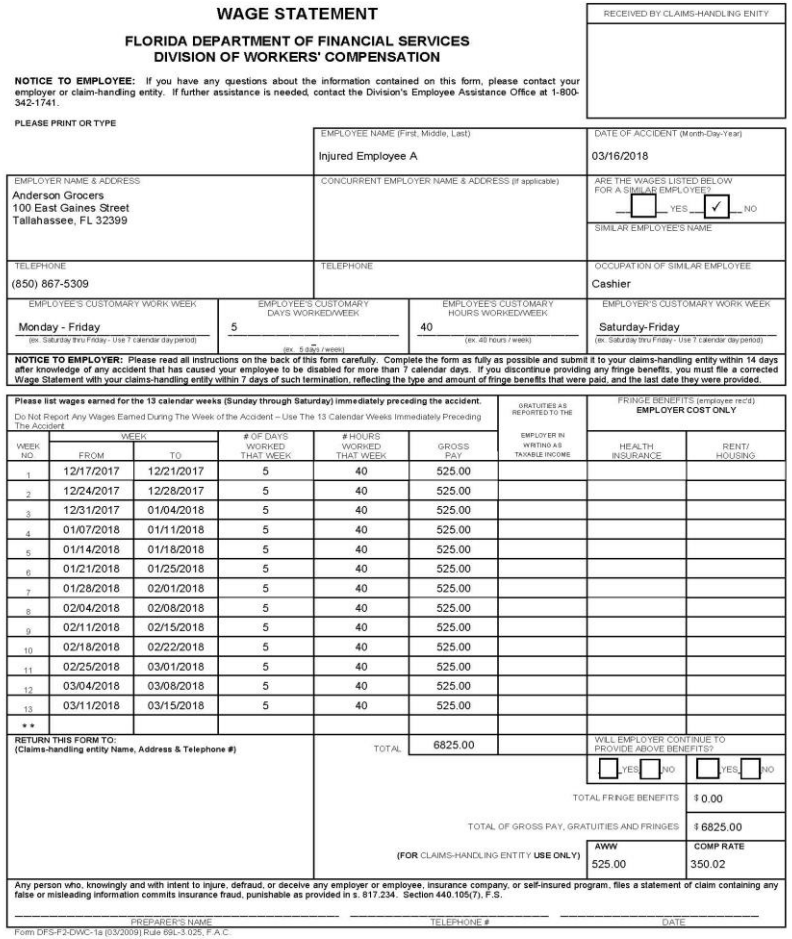
What is the Comp Rate (CR)?

Calculation of CR

AWW x .6667

$525.00 x .6667= $350.02

$525.00 (AWW) and $350.02 (CR)



WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENTITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

EMPLOYEE NAME (First, Middle, Last): Injured Employee A

DATE OF ACCIDENT (Month-Day-Year): 03/16/2018

EMPLOYER NAME & ADDRESS: Anderson Grocers, 100 East Gaines Street, Tallahassee, FL 32399

CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)

ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? ☐ YES ☑ NO

SIMILAR EMPLOYEE'S NAME

TELEPHONE: (850) 867-5309

TELEPHONE

OCCUPATION OF SIMILAR EMPLOYEE: Cashier

EMPLOYEE'S CUSTOMARY WORK WEEK	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK	EMPLOYER'S CUSTOMARY WORK WEEK
Monday - Friday (ex. Saturday thru Friday - Use 7 calendar day period)	5 (ex. 5 days / week)	40 (ex. 40 hours / week)	Saturday-Friday (ex. Saturday thru Friday - Use 7 calendar day period)

NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident.
Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: HEALTH INSURANCE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: RENT/ HOUSING
1	12/17/2017	12/21/2017	5	40	525.00			
2	12/24/2017	12/28/2017	5	40	525.00			
3	12/31/2017	01/04/2018	5	40	525.00			
4	01/07/2018	01/11/2018	5	40	525.00			
5	01/14/2018	01/18/2018	5	40	525.00			
6	01/21/2018	01/25/2018	5	40	525.00			
7	01/28/2018	02/01/2018	5	40	525.00			
8	02/04/2018	02/08/2018	5	40	525.00			
9	02/11/2018	02/15/2018	5	40	525.00			
10	02/18/2018	02/22/2018	5	40	525.00			
11	02/25/2018	03/01/2018	5	40	525.00			
12	03/04/2018	03/08/2018	5	40	525.00			
13	03/11/2018	03/15/2018	5	40	525.00			
**								

RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)

TOTAL 6825.00

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? ☐ YES ☐ NO ☐ YES ☐ NO

TOTAL FRINGE BENEFITS $ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES $ 6825.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW 525.00 COMP RATE 350.02

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.

PREPARER'S NAME _____ TELEPHONE # _____ DATE _____

Form DFS-F2-DWC-1a (03/2009) Rule 69L-3.025, F.A.C.

Lost-Time Claim Scenario #2

DOI: 3-16-18

Date Disability Began: 6-17-18

Waiting Week: 6-17- to 6-23-18

Employer wage statement provided includes 10 weeks of earnings preceding the accident = $5,250.00

What is the AWW?

Gross total /weeks

$5,250/10= $525.00 (AWW)

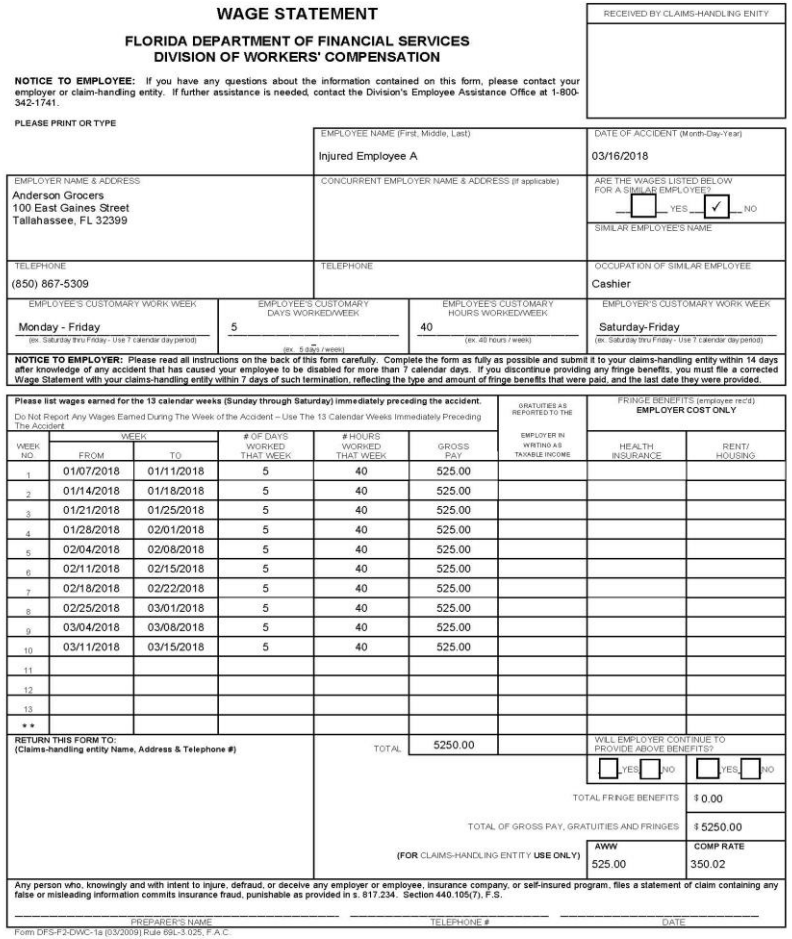
What is the Comp Rate (CR)?

Calculation of CR

AWW x.6667

$525.00 x .6667= $350.02

$525.00 (AWW) and $350.02 (CR)



WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENTITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

EMPLOYEE NAME (First, Middle, Last): Injured Employee A

DATE OF ACCIDENT (Month-Day-Year): 03/16/2018

EMPLOYER NAME & ADDRESS: Anderson Grocers, 100 East Gaines Street, Tallahassee, FL 32399

CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)

ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? ☐ YES ☑ NO

SIMILAR EMPLOYEE'S NAME

TELEPHONE: (850) 867-5309

TELEPHONE

OCCUPATION OF SIMILAR EMPLOYEE: Cashier

EMPLOYEE'S CUSTOMARY WORK WEEK	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK	EMPLOYER'S CUSTOMARY WORK WEEK
Monday - Friday (ex. Saturday thru Friday - Use 7 calendar day period)	5 (ex. 5 days / week)	40 (ex. 40 hours / week)	Saturday-Friday (ex. Saturday thru Friday - Use 7 calendar day period)

NOTICE TO EMPLOYER: Please read all instructions on the back of this form carefully. Complete the form as fully as possible and submit it to your claims-handling entity within 14 days after knowledge of any accident that has caused your employee to be disabled for more than 7 calendar days. If you discontinue providing any fringe benefits, you must file a corrected Wage Statement with your claims-handling entity within 7 days of such termination, reflecting the type and amount of fringe benefits that were paid, and the last date they were provided.

Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident.
Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: HEALTH INSURANCE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: RENT/ HOUSING
1	01/07/2018	01/11/2018	5	40	525.00			
2	01/14/2018	01/18/2018	5	40	525.00			
3	01/21/2018	01/25/2018	5	40	525.00			
4	01/28/2018	02/01/2018	5	40	525.00			
5	02/04/2018	02/08/2018	5	40	525.00			
6	02/11/2018	02/15/2018	5	40	525.00			
7	02/18/2018	02/22/2018	5	40	525.00			
8	02/25/2018	03/01/2018	5	40	525.00			
9	03/04/2018	03/08/2018	5	40	525.00			
10	03/11/2018	03/15/2018	5	40	525.00			
11								
12								
13								
**								

RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)

TOTAL 5250.00

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? ☐ YES ☐ NO ☐ YES ☐ NO

TOTAL FRINGE BENEFITS $ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES $ 5250.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW 525.00 COMP RATE 350.02

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.

PREPARER'S NAME _____ TELEPHONE # _____ DATE _____

Form DFS-F2-DWC-1a (03/2009) Rule 69L-3.025, F.A.C.

Lost-Time Claim Scenario #3

DOI: 3-16-18
Date Disability Began: 6-17-18
Waiting Week: 6-17- to 6-23-18
Employment date: 03/10/2018

The employee has only worked for 5 days, therefore 13 weeks of wages are not available to report.

How would the AWW be calculated?

440.14(1)(b) states that if the injured employee has not worked in such employment during substantially the whole of 13 weeks immediately preceding the accident, the wages of a similar employee in the same employment who has worked substantially the whole of such 13 weeks shall be used in making the determination under the preceding paragraph.

There are a few different ways to calculate the AWW and CR.

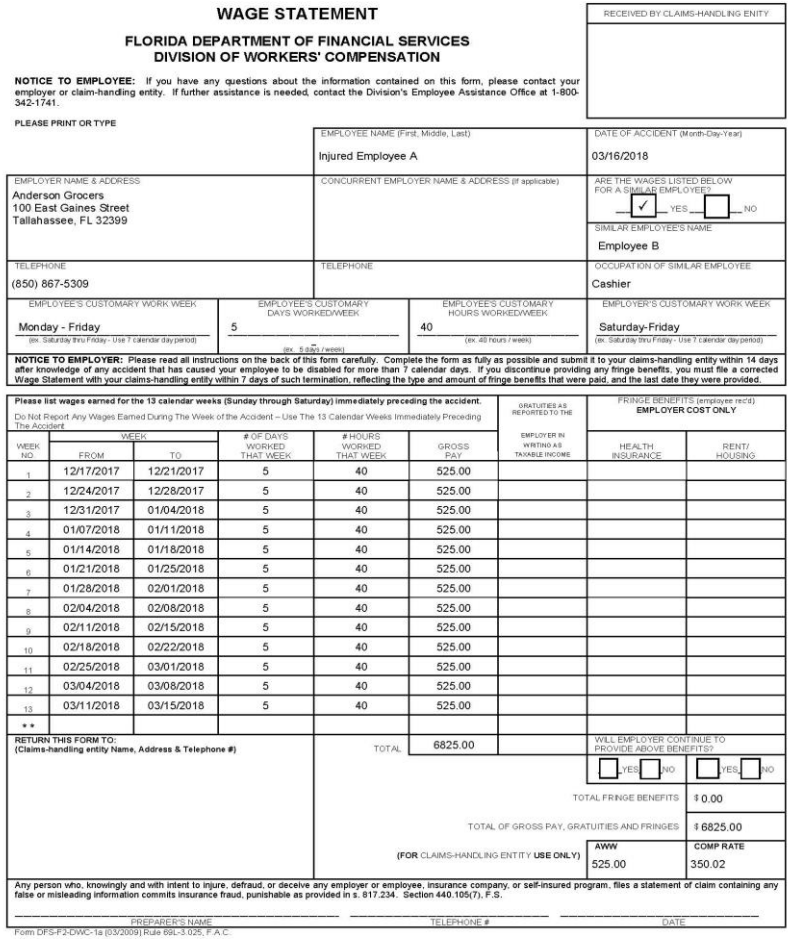
Similar Employee:

If the injured worker has not been working at the place of employment at least 13 weeks preceding the date of accident, the wages of a similar employee who has worked the whole of such 13 weeks shall be used in making the determination of the AWW for the injured worker.

Gross total /weeks
$6,825.00 */13=* $525.00 *(AWW)*

Calculation of CR
AWW x.6667
$525.00 x .6667= $ 350.02

$525.00 (AWW) and $350.02 (CR)



WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENTITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

EMPLOYEE NAME (First, Middle, Last): Injured Employee A

DATE OF ACCIDENT (Month-Day-Year): 03/16/2018

EMPLOYER NAME & ADDRESS: Anderson Grocers, 100 East Gaines Street, Tallahassee, FL 32399

CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)

ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? [✓] YES [ ] NO

SIMILAR EMPLOYEE'S NAME: Employee B

TELEPHONE: (850) 867-5309

TELEPHONE

OCCUPATION OF SIMILAR EMPLOYEE: Cashier

EMPLOYEE'S CUSTOMARY WORK WEEK	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK	EMPLOYER'S CUSTOMARY WORK WEEK
Monday - Friday (ex. Saturday thru Friday - Use 7 calendar day period)	5 (ex. 5 days / week)	40 (ex. 40 hours / week)	Saturday-Friday (ex. Saturday thru Friday - Use 7 calendar day period)

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1	12/17/2017	12/21/2017	5	40	525.00			
2	12/24/2017	12/28/2017	5	40	525.00			
3	12/31/2017	01/04/2018	5	40	525.00			
4	01/07/2018	01/11/2018	5	40	525.00			
5	01/14/2018	01/18/2018	5	40	525.00			
6	01/21/2018	01/25/2018	5	40	525.00			
7	01/28/2018	02/01/2018	5	40	525.00			
8	02/04/2018	02/08/2018	5	40	525.00			
9	02/11/2018	02/15/2018	5	40	525.00			
10	02/18/2018	02/22/2018	5	40	525.00			
11	02/25/2018	03/01/2018	5	40	525.00			
12	03/04/2018	03/08/2018	5	40	525.00			
13	03/11/2018	03/15/2018	5	40	525.00			
**								

RETURN THIS FORM TO: (Claims-handling entity Name, Address & Telephone #)

TOTAL 6825.00

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? [ ] YES [ ] NO [ ] YES [ ] NO

TOTAL FRINGE BENEFITS $ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES $ 6825.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW 525.00 COMP RATE 350.02

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.

PREPARER'S NAME _____ TELEPHONE # _____ DATE _____

Form DFS-F2-DWC-1a (03/2009) Rule 69L-3.025, F.A.C.

Rate of Pay/Contract of Hire:

The Claim Administrator may use the rate of pay or actual wages of the injured worker by collecting the hourly rate the injured worker is paid and the number of hours they work on a weekly basis.

Lost-Time Claim Scenario #4

DOI: 3-16-18
Date Disability Began: 6-17-18
Waiting Week: 6-17- to 6-23-18

Employees hourly rate of pay : $10
There is no similar employee.
Employment date: 03/10/18

Hourly rate $10.00
Work week: 40 hours
$10.00 *x 40*= $400.00 *(AWW)*

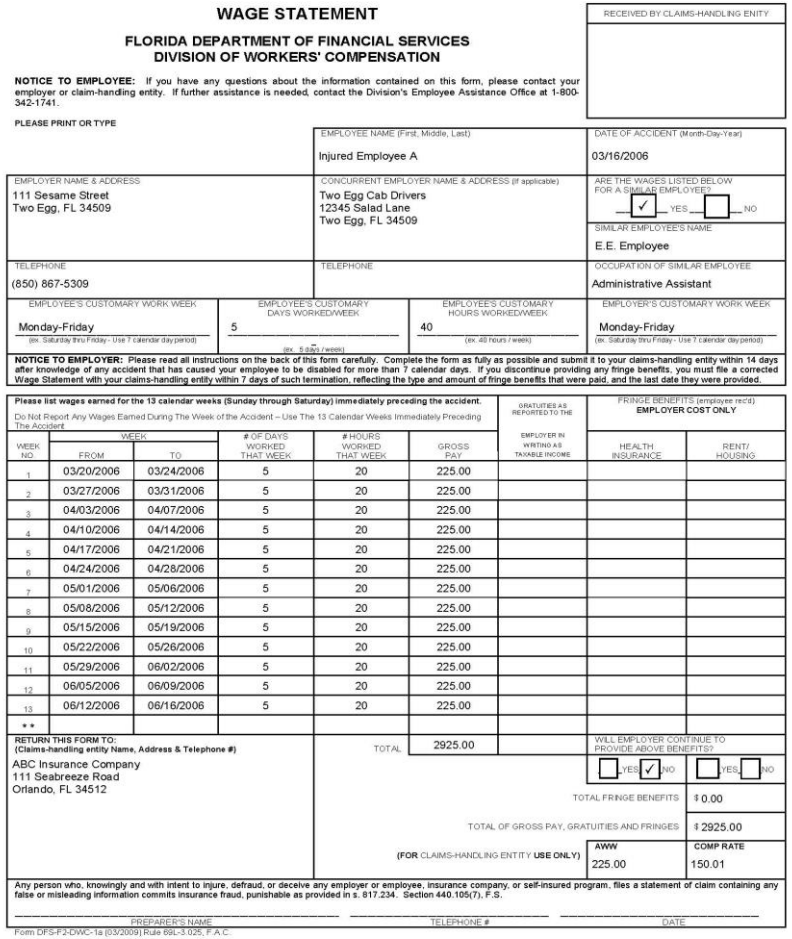
Calculation of CR
AWW x.6667
$400.00 x .6667= $ 266.68

$400.00 (AWW) and $266.68 (CR)

Concurrent Employment

If the injured worker has been working at an additional place of employment, then those wages are to be calculated into the wages from primary employment

The injured worker *is responsible* for providing the concurrent wages to the employer and/or the claims administrator for accurate calculation of the average weekly wage and compensation rate.



WAGE STATEMENT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

RECEIVED BY CLAIMS-HANDLING ENTITY

NOTICE TO EMPLOYEE: If you have any questions about the information contained on this form, please contact your employer or claim-handling entity. If further assistance is needed, contact the Division's Employee Assistance Office at 1-800-342-1741.

PLEASE PRINT OR TYPE

EMPLOYEE NAME (First, Middle, Last)	DATE OF ACCIDENT (Month-Day-Year)
Injured Employee A	03/16/2006

EMPLOYER NAME & ADDRESS	CONCURRENT EMPLOYER NAME & ADDRESS (if applicable)	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE?
111 Sesame Street Two Egg, FL 34509	Two Egg Cab Drivers 12345 Salad Lane Two Egg, FL 34509	☑ YES ☐ NO SIMILAR EMPLOYEE'S NAME: E.E. Employee

TELEPHONE	TELEPHONE	OCCUPATION OF SIMILAR EMPLOYEE
(850) 867-5309		Administrative Assistant

EMPLOYEE'S CUSTOMARY WORK WEEK (ex. Saturday thru Friday - Use 7 calendar day period)	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK (ex. 5 days / week)	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK (ex. 40 hours / week)	EMPLOYER'S CUSTOMARY WORK WEEK (ex. Saturday thru Friday - Use 7 calendar day period)
Monday-Friday	5	40	Monday-Friday

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Please list wages earned for the 13 calendar weeks (Sunday through Saturday) immediately preceding the accident.
Do Not Report Any Wages Earned During The Week of the Accident – Use The 13 Calendar Weeks Immediately Preceding The Accident

WEEK NO.	WEEK FROM	WEEK TO	# OF DAYS WORKED THAT WEEK	# HOURS WORKED THAT WEEK	GROSS PAY	GRATUITIES AS REPORTED TO THE EMPLOYER IN WRITING AS TAXABLE INCOME	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: HEALTH INSURANCE	FRINGE BENEFITS (employee rec'd) EMPLOYER COST ONLY: RENT/ HOUSING
1	03/20/2006	03/24/2006	5	20	225.00			
2	03/27/2006	03/31/2006	5	20	225.00			
3	04/03/2006	04/07/2006	5	20	225.00			
4	04/10/2006	04/14/2006	5	20	225.00			
5	04/17/2006	04/21/2006	5	20	225.00			
6	04/24/2006	04/28/2006	5	20	225.00			
7	05/01/2006	05/06/2006	5	20	225.00			
8	05/08/2006	05/12/2006	5	20	225.00			
9	05/15/2006	05/19/2006	5	20	225.00			
10	05/22/2006	05/26/2006	5	20	225.00			
11	05/29/2006	06/02/2006	5	20	225.00			
12	06/05/2006	06/09/2006	5	20	225.00			
13	06/12/2006	06/16/2006	5	20	225.00			
**								
		TOTAL			2925.00			

RETURN THIS FORM TO:
(Claims-handling entity Name, Address & Telephone #)
ABC Insurance Company
111 Seabreeze Road
Orlando, FL 34512

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS? ☐ YES ☑ NO ☐ YES ☐ NO

TOTAL FRINGE BENEFITS $ 0.00

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES $ 2925.00

(FOR CLAIMS-HANDLING ENTITY USE ONLY) AWW 225.00 COMP RATE 150.01

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PREPARER'S NAME _____ TELEPHONE # _____ DATE _____

Form DFS-F2-DWC-1a [03/2009] Rule 69L-3.025, F.A.C.

Benefit Calculators

In an effort to help stakeholders evaluate their benefit information, the Division provides a set of online benefit calculators on its web site.

The information and interactive calculators are made available to everyone as self-help tools for each person's independent use.

The Division cannot and does not guarantee their applicability or accuracy regarding each person's individual circumstances.

The Division offers three types of benefit calculators:

Temporary Total Disability,

Temporary Partial Disability, and

Impairment Income

If you have any questions about the calculation of benefits, or with estimating benefits, please contact the Bureau of Monitoring and Audit at (850) 413-1608.

DEPARTMENT OF FINANCIAL SERVICES