FLORIDA

FHM INSURANCE COMPANY

A POLICY TO **DO MORE**®

Workers' Comp Since 1954

FLORIDA-SPECIFIC
WORKERS' COMPENSATION INFORMATION
http://www.myfloridacfo.com/WC/

DRUG-FREE WORKPLACE

Drug- Free Workplace

A 5.0% premium credit is available for companies that are certified through the application process (NCCI form 09-01) to the insurance carrier and are renewed annually.

The Drug-Free Workplace application, as well as other forms, is available at our web site, **www.fhmic.com**.

Required Testing
- Pre-employment (All employees)
- Reasonable suspicion
- Post rehabilitation follow-up
- Post accident
- Routine fitness for duty

Training – Recommended annually
Sample Program can be found at **http://www.fldfs.com/wc/pdf/DFWPman.pdf**

SAFETY

Workplace Safety Programs

A 2% premium credit is available for companies certified through the insurance carrier and are renewed annually.

Required elements:
1. Written Safety Policy and Safety Rules
2. Safety Inspections
3. Preventative Maintenance
4. Safety Training
5. First Aid
6. Accident Investigation
7. Necessary Record Keeping

OUTSIDE SAFETY RESOURCES

Safety Consultation, Training & Videos

The University of South Florida offers free safety services to small businesses (250 employees or less) in Florida. Service offered include:

- On-site consultation
- Training courses
- Standards information
- Safety videos
- Technical publications
- Lecture materials
- Main office is located at:
  13201 Bruce B. Downs Blvd, MDC 56. Tampa, FL 33612
  (866) 273-1105
- Information: **www.usfsafetyflorida.com**

OSHA Information

Florida is a Federal OSHA plan state (Region 4). Office locations are:

1. Fort Lauderdale Area Office 8040 Peters Road, Building H-100 Fort Lauderdale, Florida 33324 (954) 424-0242 Phone (954) 424-3073 FAX
2. Jacksonville Area Office Ribault Building, Suite 227 1851 Executive Center Drive Jacksonville, Florida 32207. Phone: (904) 232-2895 ; Fax: (904) 232-1294
3. Tampa Area Office 5807 Breckenridge Parkway, Suite A Tampa, Florida 33610-4249 Phone: (813) 626-1177; Fax: (813) 626-7015

Safety Resources

- **http://www.usfsafetyflorida.com**
- **http://www.osha.gov/Publications/smallbusiness/small-business.pdf**
- **http://www.toolboxtopics.com**
- **http://www.tdi.state.tx.us/wc/safety/videoresources/index.html**
- **http://www.ehs.cornell.edu/msds/msds.cfm**
- **http://www.msdssearch.com**
- **http://hazard.com**
- **http://www.pp.okstate.edu/ehs**
- **http://siri.uvm.edu**
- **http://www.free-training.com**
- **http://www.fhmic.com/policyholder/forms/**

WEBSITES TO ASSIST WITH HIRING AND SCREENING

- **http://www.dc.state.fl.us/appcommon/**
- **http://www.nsopr.gov**
- **https://apps.fldfs.com/claimsweb/ClaimSearch.aspx**
- **http://www.jcc.state.fl.us/jcc/searchJCC/**
- **http://www.fldfs.com/WC/databases.html**
- **http://www.hsmv.state.fl.us/**
- **http://www.backgroundchecks.com**
- **http://www.fdle.state.fl.us/criminalhistory/**
- **http://pacer.psc.uscourts.gov/register.html**
- **http://www.searchsystems.net/**

*For the most up-to-date websites, visit **www.fhmic.com/safetynet/resources**

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: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

EMPLOYEE'S DESCRIPTION OF ACCIDENT (Include Cause of Injury)

OCCUPATION

INJURY/ILLNESS THAT OCCURRED

PART OF BODY AFFECTED

DATE OF BIRTH _____ / _____ / _____

SEX ☐ M ☐ F

EMPLOYER INFORMATION

COMPANY NAME: _____

D. B. A.: _____

Street: _____

City: _____ State: _____ Zip: _____

TELEPHONE Area Code Number

FEDERAL I.D. NUMBER (FEIN)

DATE FIRST REPORTED (Month/Day/Year)

NATURE OF BUSINESS

POLICY/MEMBER NUMBER

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 TELEPHONE OF PHYSICIAN OR HOSPITAL

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 CODE # | EMPLOYEE'S CLASS CODE | EMPLOYER'S NAICS CODE

SERVICE CO/TPA CODE # | **CLAIMS-HANDLING ENTITY** FILE #

INSURER NAME
FHM Insurance Company

CLAIMS-HANDLING ENTITY NAME, ADDRESS & TELEPHONE
Claims Serviced by: USIS
P.O. Box 616648, Orlando, FL 32861-6648
(407)351-1212 (888)346-3461

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

DWC-1 Purpose and Use Statement

The collection of the social security number on this form is specifically authorized by Section 440.185(2), Florida Statutes. 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.

WAGE STATEMENT

FOR CARRIER'S DATE STAMP
REC'D BY CARRIER

FLORIDA DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
DIVISION OF WORKERS' COMPENSATION

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

PLEASE PRINT OR TYPE

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	DATE OF ACCIDENT (mm/dd/yyyy)
EMPLOYER NAME & ADDRESS: Street: _____ City: _____ State: _____ Zip: _____	CONCURRENT EMPLOYER NAME & ADDRESS (If applicable): Street: _____ City: _____ State: _____ Zip: _____	ARE THE WAGES LISTED BELOW FOR A SIMILAR EMPLOYEE? YES NO SIMILAR EMPLOYEE'S NAME:
TELEPHONE	TELEPHONE	SSN OF SIMILAR EMPLOYEE

EMPLOYEE'S CUSTOMARY WORK WEEK:	EMPLOYEE'S CUSTOMARY DAYS WORKED/WEEK:	EMPLOYEE'S CUSTOMARY HOURS WORKED/WEEK:	OCCUPATION OF SIMILAR EMPLOYEE
(ex. Saturday thru Friday – Use 7 calendar day period)	(ex. 5 days / week)	(ex. 40 hours / week)	

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 carrier 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 carrier 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 91 day period immediately preceding the accident.
DO NOT combine wages of two or more employees.

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	RENT/ HOUSING
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
TOTAL								

RETURN THIS FORM TO:
(Carrier Name, Address & Telephone#)

FHM Insurance Company
Serviced By: UNITED SELF INSURED SERVICES
P.O. Box 616648, Orlando, FL 32861-6648
407-351-1212 888-346-3461

WILL EMPLOYER CONTINUE TO PROVIDE ABOVE BENEFITS?

YES	NO	YES	NO

TOTAL FRINGE BENEFITS $

TOTAL OF GROSS PAY, GRATUITIES AND FRINGES $

(FOR CARRIER USE ONLY) **AWW** **COMP RATE**

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, is guilty of a felony of the third degree.

PREPARER'S NAME	TELEPHONE	**DATE** (mm/dd/yyyy)

LES Form DWC-1a (11/96)

NOTICE OF ELECTION TO BE EXEMPT

Please thoroughly read the instructions before completing this application. Print legibly in each data entry field. If this application contains incomplete or inaccurate information or if the handwriting is not legible, it may cause a delay in the issuance of your exemption.

SECTION 1:

Applicant Name (please print): _____

Applicant's social security number or individual taxpayer ID: ____/____/____

Applicant's E-mail address (optional): _____

SECTION 2: I am applying for exemption as a (You must check only one box in this section):

CONSTRUCTION INDUSTRY ($50 FEE REQUIRED)

☐ Officer of a Corporation (Title): _____ **-OR-** ☐ Member of a Limited Liability Company (LLC)

NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED)

☐ Officer of a Corporation (Title): _____)

The Division will accept a money order, a cashier's check, or an electronic payment made payable to the DFS WC Administration Trust Fund.

An officer electing an exemption under Chapter 440, Florida Statutes is not entitled to benefits under this chapter.

SECTION 3. To be eligible for an exemption, the corporation of which you are an officer or the limited liability company of which you are a member must be registered with the Florida Division of Corporations. For applicants applying as an officer of a corporation, you must be listed as an officer of the Corporation with the Florida Division of Corporations. List the document number (document number shown on your Annual Report) on file with the Florida Division of Corporations.

_____

SECTION 4. This exemption application applies only to the person signing the application, the Corporation/LLC that is listed below, and the scope of business or trade listed:

Name of Corporation or LLC: _____ FEIN: _____
AS REGISTERED WITH THE FLORIDA DIVISION OF CORPORATIONS

Business Name: _____ Phone: (___) _____
IF APPLICABLE – LIST FICTIOUS NAME; DOING BUSINESS AS (DBA); ALSO KNOW N AS NAME (AKA)

Business Mailing Address: _____
INCLUDE APARTMENT OR SUITE NUMBER

City: _____ State: _____ Zip: _____ County: _____

Scope of Business or Trade of Applicant: 1. _____ 2. _____ 3. _____

SECTION 5. List all certified or registered licenses issued pursuant to Chapter 489, F.S. held by the applicant, or the certified or registered license numbers held by the qualifier for the corporation or LLC listed on this application of which the applicant is a corporate officer: _____

SECTION 6. Does the county or municipality in which your business is located require an occupational license for your business?

☐ Yes ☐ No **IF YES, A COPY OF A CURRENT OCCUPATIONAL LICENSE MUST BE ATTACHED.**

SECTION 7. Are you affiliated with any corporation (including LLC) other than the corporation (including LLC) to which this application applies? ☐Yes ☐ No

IF YES, PLEASE LIST THE NAME(s) AND FEIN(s) OF THE AFFILIATED CORPORATION(s) OR LLC(s):

NAME: _____ **FEIN:** _____

SECTION 8. If your corporation or LLC is engaged in the construction industry, you must provide the required proof of ownership in the corporation or LLC.

A. To be eligible for a construction industry exemption as an officer of a corporation, the applicant must be a shareholder, owning at least 10% of the stock of the corporation. **A COPY OF A STOCK CERTIFICATE EVIDENCING THE REQUIRED OWNERSHIP MUST BE ATTACHED.**

B. To be eligible for a construction industry exemption as a member of a limited liability company, the applicant must confirm ownership of at least 10% of the company. **THE REQUIRED OWNERSHIP MAY BE ESTABLISHED BY PRODUCTION OF DOCUMENTATION REFLECTING THE REQUIRED OWNERSHIP, OR BY SUBMITTING A STATEMENT ATTESTING TO THE REQUIRED OWNERSHIP.**

THIS APPLICATION IS CONTINUED ON PAGE 2

SECTION 9. **FRAUD NOTICE**

A. **Any person who, knowingly and with intent to injure, defraud, or deceive the department or any employer or employee, insurance company or any other person, files a notice of election to be exempt containing any false or misleading information is guilty of a felony of the third degree.**

B. **Attestation of applicant - By signing below, I attest that I have read, understand and acknowledge the foregoing notice.**

_____
SIGNATURE OF APPLICANT

SECTION 10. You must identify the workers' compensation insurance carrier that covers any non-exempt employees of your business. **Carrier Name:** _____

AFFIDAVIT OF APPLICANT: I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers, including any affiliated corporations as provided in §440.02 Florida Statutes.

_____ _____
APPLICANT'S SIGNATURE DATE SIGNED

NOTARY STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed before me this_____ day of _____, _____, by _____

Personally Known_____ OR Produced Identification_____ Type of Identification Produced_____

NOTARY SIGNATURE My Commission Expires _____

Please mail or submit your completed application, application fee, and any required attachments to the district office nearest your place of business.

4415 Metro Parkway
Suite #300
Ft. Myers FL 33916
Telephone (239) 938-1840

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7804

3111 S. Dixie Highway
Suite #123
West Palm Beach FL 33405
Telephone (561) 837-5716

1718 Main Street, Suite 201
Sarasota FL 34236
Telephone (941) 329-1120

921 N. Davis Street
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

400 West Robinson Street
Room #512, North Tower
Orlando FL 32801
Telephone (407) 835-4406 or (407) 245-0896

499 Northwest 70th Avenue
Suite #116
Plantation FL 33317
Telephone (954) 321-2906

1313 N. Tampa Street
Suite #503
Tampa FL 33602
Telephone (813) 221-6506

401 NW 2nd Avenue
Suite #321, South Tower
Miami FL 33128
Telephone (305) 536-0306

1111 NE 25th Avenue
Suite #403
Ocala FL 34470
Telephone (352) 401-5350

TALLAHASSEE SUBMITTERS

***Walk-in submissions*:**
2012 Capital Circle SE
Suite #102, Hartman Bldg.
Tallahassee FL 32399-2161
Telephone (850) 413-1609

***Mail in submissions*:**
200 East Gaines Street
Tallahassee FL 32399-4228
Telephone (850) 413-1609

STATE USE ONLY

Effective/Issue Date:

Expiration Date:

Control Number:

Postmark Date:

Received Date:

Payment Number:

NOTICE OF REVOCATION OF ELECTION TO BE EXEMPT

STATE USE ONLY
Effective/Issue Date:
Control Number:
Postmark Date:
Received Date:

PLEASE TYPE OR PRINT

I hereby revoke the exemption I currently have as a (check only one box in this section):

CONSTRUCTION INDUSTRY

☐ Corporate Officer (your corporate title: _____) ☐ Member of Limited Liability Company **-OR-**

NON-CONSTRUCTION INDUSTRY

☐ Corporate Officer (your corporate title: _____)

THIS REVOCATION OF ELECTION TO BE EXEMPT APPLIES ONLY TO THE PERSON SIGNING THE REVOCATION AND ONLY TO THE CORPORATION/LLC THAT IS LISTED IN THE FOLLOWING SECTION:

Corporation or LLC Name:			
Business Mailing Address:	City:	State:	Zip:
County:	Phone No.: ( )	FEIN:	Corporate registration number:

Scope of Business or Trade of Applicant Listed on Notice of Election to be Exempt:

1. _____ 2. _____ 3. _____ 4. _____

You must identify the workers' compensation insurance carrier that covers any non-exempt employees of your business.
Carrier Name: _____

PURSUANT TO SECTION 440.05 (3) FLORIDA STATUTES, UPON FILING A NOTICE OF REVOCATION, IF YOU ARE AN OFFICER WHO IS A SUBCONTRACTOR OR AN OFFICER OF A CORPORATE SUBCONTRACTOR, YOU MUST NOTIFY YOUR CONTRACTOR THAT YOU HAVE REVOKED YOUR EXEMPTION.

PURSUANT TO SECTION 440.05 (3) FLORIDA STATUTES, UPON REVOCATION OF A CERTIFICATE OF ELECTION OF EXEMPTION BY THE DEPARTMENT, THE DEPARTMENT SHALL NOTIFY THE WORKERS' COMPENSATION CARRIER(S) IDENTIFIED IN THE REQUEST FOR EXEMPTION.

_____ _____

TYPE/PRINT NAME OF EXEMPTION HOLDER SOCIAL SECURITY NUMBER

_____ _____

SIGNATURE OF EXEMPTION HOLDER DATE SIGNED

Workers' Compensation Information Online - http://www.fldfs.com/WC/

SUBMIT THIS FORM TO THE DISTRICT OFFICE LISTED BELOW THAT IS CLOSEST TO YOUR PLACE OF BUSINESS:

WORKERS' COMPENSATION COMPLIANCE FIELD OFFICES

4415 Metro Parkway
Suite #300
Ft. Myers FL 33916
Telephone (239) 938-1840

3111 South Dixie Hwy.
Suite #123
West Palm Beach FL 33405
Telephone (561) 837-5716

1718 Main St.
Suite #201
Sarasota FL 34236
Telephone (941) 329-1120

401 NW 2nd Ave.
Suite S-321
Miami FL 33128-1740
Telephone (305) 536-0306

921 N. Davis St.
Building B, Suite #250
Jacksonville, FL 32209
Telephone (904) 798-5806

1313 North Tampa Street
Suite #503
Tampa FL 33602
Telephone (813) 221-6506

499 Northwest 70th Avenue
Suite #116
Plantation FL 33317
Telephone (954) 321-2906

400 West Robinson St.
North Tower, Suite N512
Orlando FL 32801-1756
Telephone (407) 245-0896 or (407) 835-4406

1111 NE 25th Ave.
Suite #403
Ocala FL 34470
Telephone (352) 401-5350

610 E. Burgess Road
Pensacola, FL 32504-6320
Telephone (850) 453-7804

TALLAHASSEE:

Walk-in submissions
2012 Capital Circle SE
Suite #102 Hartman Bldg.
Tallahassee FL 32399-2161
Telephone (850) 413-1609

Mail in submissions
200 East Gaines Street
Tallahassee FL 32399-4228
Telephone (850) 413-1609

Workers' Compensation Information Online - http://www.fldfs.com/WC/

INSTRUCTIONS FOR COMPLETING NOTICE OF ELECTION TO BE EXEMPT

IMPORTANT INFORMATION:

Only corporate officers or members of a limited liability company (LLC) engaged in the construction industry are eligible for an exemption. Non-construction LLC members are NOT ELIGIBLE for an exemption.

Under the law, the Division has 30 days to review your application to determine if it meets the eligibility requirements for the issuance of an exemption. The Division will either issue a Certificate of Election to be Exempt to you if your application is complete or notify you by mail that your application is incomplete and what information or documents are needed to complete the application. The Division reviews and processes exemption applications in the order they are received. Applicants filing this application to renew a current exemption should submit the application to the Division at least 45 days prior to the expiration date of their current exemption.

You can visit the Division's website at http://www.fldfs.com/WC/ and click on the Proof of Coverage icon on the right hand side of the page. As soon as the Division issues your exemption, it will be reflected on the Proof of Coverage database and your certificate of exemption will be mailed the day after it is issued. You should receive your Certificate of Election to be Exempt 7-10 days after the exemption has been issued.

If your corporation is dissolved or inactive, your Notice of Election to be Exempt will be DENIED. If the Notice of Election to be Exempt is denied, the applicant must submit a new Notice of Election to be Exempt and, if the applicant is engaged in the construction industry, another $50.00 fee is required.

An exemption is subject to revocation if the person named on the certificate no longer meets any of the requirements to be eligible for an exemption.

If you have any questions in regards to completing this application, please call the Division's Customer Service Center at (850) 413-1609 and press option #2.

SECTION 1. Print your name and social security number, or individual taxpayer identification number. Please list your e-mail address. In addition to mailing a future renewal application to you, the Division will also e-mail the renewal application to you.

SECTION 2. If you are applying for an exemption as an officer of a corporation or member of a limited liability company engaged in the construction industry, you must check one of the boxes beneath the heading **"CONSTRUCTION INDUSTRY" ($50 FEE REQUIRED). The Division will accept a money order, a cashier's check or an electronic payment made payable to the DFS WC Administration Trust Fund.** If you are applying as an officer of a corporation, you must list your corporate title (no abbreviations please).

If you are applying for exemption as an officer of a corporation not engaged in the construction industry, you must check the box next to "Officer of a Corporation" beneath the heading **NON-CONSTRUCTION INDUSTRY (NO FEE REQUIRED),** and list your corporate title (no abbreviations please).

SECTION 3. The registration number is the document number that was assigned to your corporation or limited liability company by the Florida Division of Corporations when your corporation or limited liability company was established. This number can be found on your annual report that you have filed with the Florida Division of Corporations. Your document number can also be found at the Florida Division of Corporation's website, http://www.sunbiz.org/. Your corporation or limited liability company must be registered with the Florida Division of Corporations. For applicants applying as an officer of a corporation, you must be listed as an officer of the Corporation with the Florida Division of Corporations.

SECTION 4. This section should be completed with information that is specific to your corporation, or to the limited liability company in which you are a member. Please include your complete **corporate name, including Inc. or Corp., or the complete name of the limited liability company**. The name of the corporation or limited liability company listed on the application must match the name of corporation or limited liability company registered with the Florida Division of Corporations. If applicable, include your fictitious name, doing business as (DBA) name, or also known as name (AKA) in the 'Business Name' field. In the mailing address area, list only one complete address, including suite or apartment number. The certificate of exemption and future renewal applications will be mailed to the address listed in this section. A federal employer identification number (FEIN) is required unless the application is for a single member limited liability company in which case the member's social security number will suffice for the limited liability company's FEIN. For information regarding FEIN, you may call the IRS at (800) 829-4933.

The certificate applies only to the corporation or limited liability company listed in this section. A new certificate must be obtained for each new or additional corporation or limited liability company employing the applicant.

Scope of Trade or Business of Applicant refers to the trade or business activity that best describes your business. The issued certificate of exemption will apply only within the scope of the business or trade listed.

SECTION 5. Certified or Registered licenses refer to any licenses that are issued by the Department of Business and Professional Regulations (DBPR) as required by Chapter 489 F.S. Contractors are required to obtain a certified or registered license from DBPR. If you need additional information about DBPR licensing requirements, please contact DBPR at (850) 487-1395 or visit their website at http://www.state.fl.us/dbpr/. If a contractor licensed under Chapter 489 F.S. has applied to Department of Business and Professional Regulations for a change of business status, the applicant should list their current license number and specify that the change of status is "Pending."

SECTION 6. Each applicant, including an applicant outside the state of Florida, must submit a copy of an occupational license required by the city or county in which the business is located or performing regular work. If the city or county does not require an occupational license, check "NO" for this section.

If the applicant is required to obtain a license issued pursuant to Chapter 489 F.S., the business name listed on the occupational license or occupational license receipt must match the name of the corporation or limited liability company listed on the Notice of Election to be Exempt or the application will be returned as incomplete.

If the applicant is not required to obtain a license issued pursuant to Chapter 489, F.S. the name of the corporation, limited liability company, or business listed on the Notice of Election to be Exempt must match the business name listed on the occupational license or occupational license receipt, or the application will be returned as incomplete.

SECTION 7. If the corporation (including any limited liability company) of which you are an officer is affiliated with other corporations, (including limited liability companies), please list the name and FEIN of each such affiliated corporation (including limited liability companies). If there is more than one affiliated corporation (including limited liability companies), please attach a separate sheet identifying the affiliated corporations (including limited liability companies).

If the corporation (including any limited liability company) of which you are an officer is not affiliated with any other corporation, (including limited liability companies), based upon the definition of "Affiliated Corporation" below, please indicate "Not Applicable."

For purposes of determining whether there are affiliated corporations of the corporation for which you are an officer, the following statutory definition applies: Affiliated corporations means and includes one or more corporations or entities, any one of which is a corporation engaged in the construction industry, under the same or substantially the same control of a group of business entities which are connected or associated so that one entity controls or has the power to control each of the other business entities. The term "affiliated" includes, but is not limited to, the officers, directors, executives, shareholders active in management, employees, and agents of the affiliated corporation. The ownership by one entity or a pooling of equipment or income among business entities shall be prima facie evidence that one business is affiliated with the other. **No more than three (3) officers of a corporation (including limited liability companies) or of any group of affiliated corporations (including limited liability companies) may elect to be exempt.**

SECTION 8. This section only applies to construction industry exemption applicants. Non-construction industry applicants do not need to complete this section.

A. **CORPORATION** - The applicant for a construction industry exemption must attach copies of the stock certificate(s) evidencing at least 10% ownership in the corporation. There is no requirement for a corporate seal or for the certificate to be notarized. At a minimum, each stock certificate must include:

- The name of the issuing corporation.
- The state under which the corporation is organized.
- The name of the person to whom the certificate is issued.
- An officer of the corporation must sign the certificate
- The percent of ownership that the issued shares represent (a stock register can be provided in lieu of this requirement).
- The number of shares issued by the corporation.

B. **LIMITED LIABILITY COMPANY** - The applicant for a construction industry exemption must produce documentation reflecting that the applicant owns at least 10% the limited liability company, or submit a statement attesting that the applicant owns at least 10% of the limited liability company.

SECTION 9. Each applicant must read the fraud notice and provide his or her signature in the appropriate area. The signature is an attestation that the fraud notice was read, understood and acknowledged.

SECTION 10. List the name of the workers' compensation insurance carrier that covers your non-exempt employees. If you do not have non-exempt employees please indicate "not applicable."

If you are in the construction industry, workers' compensation coverage must be secured once you employ one or more employees. If you are in the non-construction industry, workers' compensation coverage must be secured once you employ four or more employees.

NOTE: Corporate officers are counted as employees unless they have been issued a certificate of election to be exempt from the Division of Workers' Compensation.

Failure to secure workers' compensation coverage as defined in S. 440.107(2), F.S., shall result in the issuance of a stop-work order and an order of penalty assessment.

AFFIDAVIT OF APPLICANT: An affidavit is a sworn statement in writing made under oath or on affirmation before an authorized officer. This section should be completed after careful review of the statement being attested to. The application should not be signed or dated until you are in the presence of a notary public.

NOTARY PUBLIC: The application must be notarized prior to submission. Any licensed notary public may notarize the application. They should not be related to you. Most banks have a notary public available to notarize documents. There may be a charge for this service. *Please be advised that workers' compensation office personnel do not notarize applications for Notice of Election to be Exempt.*

NO INJURY CERTIFICATE

Employer: _____

Location/Department: _____

(Initial and complete as appropriate)

__ I have not suffered any injury during my employment period _____ (date) through _____ (date).

__ I suffered an injury to my _____ (part of body) on _____ (date) during my employment, which was (___) was not (___) reported to my supervisor _____ (name).

I have (__) or have not (__) witnessed an accident resulting in injury to someone else.

IMPORTANT NOTICE: **THIS REPORT IS FOR INJURY REPORTING PURPOSES ONLY. BY FLORIDA LAW AN EMPLOYER MUST PAY WAGES EARNED BY AN EMPLOYEE WITHOUT IMPOSING ANY CONDITIONS SUCH AS SIGNING THIS FORM. NO EMPLOYEE WILL BE REQUIRED TO FILL OUT THIS FORM IN ORDER TO RECEIVE HIS OR HER WAGES.**

I certify that I have signed this form freely and voluntarily for reporting purposes only.

_____ _____

Employee Signature Date

REFUSAL OF TREATMENT

TODAY'S DATE: _____

EMPLOYEE NAME: _____

As of the date noted above I am notifying my employer of an injury that occurred on

(DATE):_____

- ❑ My supervisor did not receive notification of this incident.
- ❑ My supervisor did receive notification of this incident on (DATE): _____

This injury, (briefly describe condition) _____

_____

did occur during my normal scope and duties.

At this time I have been requested by my employer to be medically evaluated by a *preferred medical provider*. However, ***I decline to be medically evaluated for the above noted condition***.

I understand that by signing this document any future claims regarding this injury will require a medical evaluation by the preferred healthcare provider listed below. I also understand that should I decide to seek medical treatment for this injury that I must first notify my supervisor and go to the following provider:

PROVIDER: _____

ADDRESS: _____

PHONE: _____

SHOULD THE CONDITION BECOME LIFE THREATENING YOU SHOULD SEEK APPROPRIATE EMERGENCY MEDICAL CARE.

EMPLOYEE STATEMENTS

By signing this form I acknowledge:

I have not sought medical treatment for this injury.

I understand that it is the policy of my employer to have a post-accident drug screen and this refusal of medical treatment does not remove the requirement that I receive a post-accident drug screen.

I have read the above information and agree it is factual and a true statement. I authorize any physician, hospital, or healthcare provider to release and furnish any, and all, medical records or other information pertaining to the above listed condition.

_____ _____

Employee Signature **Supervisor / Witness Signature**

_____ _____

Date **Date**

06/11

Introductory Letter to Physician

AmeriSys / Coventry

Date: _____

Employer Name: _____

Employer Telephone Number: _____

Dear Dr. _____ :

_____ is scheduled for an initial visit as an employee of _____ which is a participant in the **FHM Insurance Company/Coventry Network**. This letter does not confirm that the injury or condition is covered by Workers' Compensation insurance. That determination will be made as soon as our claims administrator, United Self Insured Services, completes an investigation.

DRUG TESTING IS REQUIRED:

☐ Urinanalysis

☐ Breathalyzer (blood test if necessary)

We are working closely with Coventry and the involved medical providers to ensure that our employees receive access to timely and medically necessary treatment for their industrial injuries. In the best interest of our employees, we will have modified work available, which would allow the employee to return to work at the earliest possible date. Please keep this in mind as you treat this employee.

PLEASE CONTACT UTILIZATION MANAGEMENT
AT 407-351-1212/888-346-3461
WHEN ONE OF THE FOLLOWING OCCURS:

1. New Injury with Disability > 7 Days & No Release to Return to Work
2. Hospitalization
3. Anticipated Surgery
4. Physical Therapy or Chiropractic Treatment Recommended
5. Referral to Provider
6. Assistance Required to Return Injured Employee to Work
7. Repeat Major Diagnostic Studies

All claims for treatment must be submitted to the address below on a HCFA 1500, UB 92 or the appropriate form required by the State. Please submit all medical reports within the time frame required by the applicable state law:

FHM Insurance Company
P.O. Box 616648, Orlando, FL 32861-6648
407-351-1212/888-346-3461 Ext 353

Should you have any questions regarding your participation in the Coventry Network, please refer to the Coventry Provider Relations Unit- 800-937-6824 or contact your representative at: Coventry Workers' Comp Services, Attn: Stephanie Claycomb, 720 Cool Springs Blvd., #300 Franklin, TN 37067

Sincerely,

_____ _____

Print Name **Signature**

Pharmacy Instruction Letter

Dear Injured Worker:

Your employer's Workers' Compensation carrier, FHM Insurance Company, has joined together with AmeriSys and myMatrixx Pharmacy Program to provide you with a quick and convenient way to get your Workers' Compensation prescription drugs. The program allows you as a member to enjoy the following:

- No out-of-pocket payments
- No need to fill out or file claim forms related to your outpatient prescription drugs
- Major pharmacy chains in the network offering quick and convenient service

Use the myMatrixx Pharmacy Form (for initial prescriptions only), given to you by your employer when you report an injury, at any of the pharmacies listed on the form. A few days after the injury is reported you will receive a prescription card from myMatrixx.

Walgreens	**Eckerd Drugs**
Publix	**Winn-Dixie**
K-Mart	**Kash N Karry**
CVS	**Wal-Mart**

If you do not have one of those pharmacies in your area, the network includes the following chains:

Target	Harco
Rite-Aid	Golden Eagle
Brunos	Medicine Shoppe
Giant Eagle	

In addition to the major chains listed above, there are other pharmacies in the **myMatrixx** program**.** If your pharmacy of choice is not listed above, please contact **myMatrixx** at 877-804-4900 to see if it is included in the network. If the pharmacy is not yet enrolled, they can be contacted about participating in the **myMatrixx Pharmacy Program.**

Reminder: ***The myMatrixx Pharmacy Form you are given by your employer is for initial prescription(s) only. It is essential that you keep in touch with your adjuster at FHM Insurance Company, 888-346-3461 or 407-351-1212. You will receive an RX card direct from myMatrixx which should be used for any subsequent prescriptions.***

If you have any questions about the **myMatrixx** program, please contact your Nurse Case-Manager at 888-346-3461.

Dear Employee: You are being sent for medical treatment or evaluation for an apparent work-related injury. Should you need prescriptions filled, please provide this form to the pharmacy for initial prescriptions only. In a few days you will receive a prescription card from myMatrixx. **The pharmacy will need your Date of Injury, Date of Birth, Social Security Number and the Group Number which is 10602144.**

Dear Pharmacist: This employee is being treated for an apparent work-related injury. Please provide a 3-day supply in accordance with the formulary.

Pharmacy Input Codes:

Wal-Mart	PP	Publix	PSP
Winn-Dixie	PRS	K-Mart	PSP
Eckerd	2343	Walgreens	PPSC
Target	PSP	Rite-Aid	PRESCRIP
Kash N Karry	PPSC	Golden Eagle	PSP
Medicine Shoppe	PSP	CVS	5792
Giant Eagle	PSP	Harco	PRESCRIP
Brunos	PPSC		

Independent pharmacies will use BIN#014211 (may be listed as Stockton Group or Pharmacy Plus).

Pharmacy: Please leave "person code" blank. **Group Number is 10602144**
If there are any questions, please contact myMatrixx at 877-804-4900.

myMatrixx Pharmacy Form

cut here ----------

Dear Employee: You are being sent for medical treatment or evaluation for an apparent work-related injury. Should you need prescriptions filled, please provide this form to the pharmacy for initial prescriptions only. In a few days you will receive a prescription card from myMatrixx. **The pharmacy will need your Date of Injury, Date of Birth, Social Security Number and the Group Number which is 10602144.**

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Giant Eagle	PSP	Harco	PRESCRIP
Brunos	PPSC		

Independent pharmacies will use BIN#014211 (may be listed as Stockton Group or Pharmacy Plus).

Pharmacy: Please leave "person code" blank. **Group Number is 10602144**
If there are any questions, please contact myMatrixx at 877-804-4900.

myMatrixx Pharmacy Form

EMPLOYEE AGREEMENT
EMPLOYEE SAFE WORKING PRACTICE/MANAGED CARE

As a condition of employment, I _____ do hereby agree to
(Please print full name)
comply with the following Employee Safe Working Practices and Managed care program.

1. I agree to follow established departmental safety procedures.

2. I agree to report any work-related accident or injury to my supervisor as soon as it occurs, but no later than the end of my duty shift.

3. If I need treatment for a work-related injury, I understand that my employer has enrolled in a Managed Care Program for Workers' Compensation with ***FHM Insurance Company WECARE Program and AmeriSys/Coventry Network*** and that the following procedures must be followed for all work-related injuries and illnesses. Treatment received outside the Workers' Compensation managed care arrangement is not compensable unless authorized by the carrier prior to the treatment date.

    - ✓ Report promptly any work-related injury to supervisor.
    - ✓ Hand carry the Introductory Letter to Physician to the approved network physician on the initial visit.
    - ✓ Follow the approved network physician's instructions for any additional specialist treatment, if needed.
    - ✓ **Ensure all medical treatment is handled only through the approved network physician.**
    - ✓ Direct all questions about level of care to the approved network physician, who is the focal point for medical treatment.
    - ✓ Follow your state's established procedures to resolve dissatisfaction with medical treatment.

I understand that failure on my part to follow the above procedures could result in disciplinary action not to exclude termination and loss of Workers' Compensation benefits.

I also understand that according to Workers' Compensation Law, my compensation benefits could be reduced for any injury that occurs because of failure to follow established safety procedures.

_____ _____
Employee Date

_____ _____
Witness Signature Date

Original to Personnel File / Copy to Employee

WORKERS' COMPENSATION WECARE NETWORK
PROVIDER NOMINATION FORM

All information in the box below must be completed prior to forwarding.
The form will be returned if incomplete.

Employer Name:	
Address:	
City, State, Zip:	
Telephone #:	
Requestor Name:	
Requestor Telephone #:	
Provider Name:	
Group Name:	
Provider Specialty:	
Address:	
City, State, Zip:	
Telephone #:	
Client's $ volume with provider:	
Period represented:	From: To:
Source of Data (1099):	
Other:	

Tax ID # (if available): _____

Contact Person (if available): _____

Hospital Affiliation (if known): _____

Reason for Nomination: _____

Comments: _____

Signature: _____ Date: _____

Please forward to:

AmeriSys
Attn: Leslie Whittemore
PO Box 616648
Orlando, FL 32861-6648
888-346-3461 x120 / Fax #: 407-949-3170

Internal Use Only:
Date Received: _____
Recruitment Letter Sent:
Date of Last Contact:
Current Status: _____

Managed Care Representative: _____

FHM Insurance Company

WECARE®

WORKERS' COMPENSATION

GRIEVANCE PROCEDURE

IF YOU ARE INJURED ON THE JOB

Your employer and Workers' Compensation carrier are concerned that you receive appropriate medical treatment.

Your employer has a list of health care providers and can assist you in selecting a provider from within the Coventry Network. If you need to be referred to another provider or need emergency care, you may choose from the list of providers participating in the Network.

If you are dissatisfied or have questions concerning the medical care and treatment provided by a **WECARE** provider, you may, within one year from the date of treatment or care in question, file a complaint by contacting the Grievance Coordinator at 888-346-3461 x417.

The Grievance Coordinator and/or Nurse Case-Manager will coordinate a resolution to the complaint and contact a Physician Advisor if necessary. The Physician Advisor may require medical examinations and/or other information from you and the Network provider depending on the nature of the dispute. If the Physician Advisor is unable to resolve the dispute to your satisfaction within ten (10) days, the matter will automatically be referred to the Medical Director.

The Medical Director will issue a decision within thirty (30) days unless further information is required, in which case an additional thirty (30) days will be allowed. If an agreement is not reached and you are not satisfied with the decision of the Medical Director, you may file a request for grievance reconsideration with the Division of Workers' Compensation.

If you have any questions concerning the Coventry Network, call 888-346-3461, ext. 120 or write to:

Coventry Health Care Workers' Compensation, Inc.
3200 Highland Avenue
Downers Grove IL 60515

Florida Workers' Compensation Managed Care Arrangement
FORMAL GRIEVANCE FORM

An Injured Worker or Health Care Provider shall use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

This Grievance is Filed by: ___Provider ___Injured Worker or a Designated Representative: ___Family Member ___Attorney ___Other
Date of Injury _____

INJURED WORKER'S/PROVIDER'S NAME: _____
Social Security Number: _____
Address: _____
Home Telephone: _____ Work/Alternate Phone: _____
Contact if other than injured worker or provider _____ Telephone # _____

PRIMARY CARE/TREATING PHYSICIAN: _____
Address: _____
Office Telephone: _____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem): _____

_____

_____

_____

_____

_____

_____

_____

Has a grievance been previously filed? ____YES ___NO IF YES, Date sent? _____

What Action Would You Like to See Taken? _____

_____

_____

_____

_____

_____

Have you received any information regarding your rights and responsibilities under WC Managed Care? Yes___ No___

INTENT: The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

The injured worker's participation in the grievance process is important to the resolution of medical issues. Individuals reviewing the grievances may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a Petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: _____ _____

Injured Worker/Provider/Other — Date Form Completed/Signed

_____ _____

Signature of Grievance Coordinator — Date Grievance Coordinator Signed

MAIL TO:

Grievance Coordinator
AmeriSys
PO Box 616648
Orlando, FL 32861-6648
407 351 1212 x 417

APPLICATION FOR POST-INJURY DRUG AND/OR ALCOHOL TESTING PROGRAM

TO:	FHM Underwriting Department	Fax No: 407-373-6441	Date:	

INFORMATION NEEDED TO REGISTER YOUR COMPANY

(Please complete all information on this page and fax to FHM Policy Services Department)

GENERAL INFORMATION

Policy No.	306-				
Company Name:					
D/B/A:					
Street:					
City:		State:		Zip:	
Phone:		Fax:			
Contact:		Email:			

YES, I am interested in registering my Company for this program:

MANAGED CARE PROVIDER INFORMATION

(Where you send your injured employee for treatment)

Provider Name:					
Street:					
City:		State:		Zip:	
Phone:		Fax:			
Contact:		Email:			

Provider Name:					
Street:					
City:		State:		Zip:	
Phone:		Fax:			
Contact:		Email:			

NO, I am not interested in registering my Company for this program:

Reason please: _____

_____

PLEASE NOTE: Your company will be responsible for the costs of drug tests conducted at a designated medical center or collection site for tests that are **NOT** part of the FHM *"Post-Accident Drug Testing Program"* (examples are: (1) Post-accident testing in which a claim is not reported; (2) Pre-Employment; (3) Random & reasonable suspicion). Also, you are **NOT** set-up to do post-accident testing until you receive *"chain of custody"* forms and further instructions from **Total Compliance Network (TCN)** – (800) 881-4826.

Company Official's Signature:			
Print Name:		Title:	

CONSENT TO EMPLOYEE DRUG AND/OR ALCOHOL TESTING

I understand that submission to a Post-Injury Drug And/Or Alcohol Screen is a condition of employment with this employer. I understand that, should my testing results be confirmed positive or I refuse to test, I will be subject to the company's disciplinary action, including possible discharge. I understand that a tampered with or an adulterated specimen will be considered a refusal to test, resulting in possible discharge.

I hereby give my consent to release the results of my blood and/or urinalysis to the person(s) or department(s) or the specified agent of my employer, including my employer's Workers' Compensation Insurance Company, for the purpose of determining the presence of alcohol and/or other drugs in my body for the duration of my employment.

I understand that if I am injured during the course and scope of my employment and I test positive for the presence of alcohol and/or drugs, I may forfeit my eligibility for medical and indemnity benefits. I also understand that a refusal to test, a tampered with or an adulterated specimen under this circumstance may also result in forfeiture of my eligibility for medical and indemnity benefits and immediate action, including possible discharge.

By signing this form, I hereby release to the Company and/or Company's Medical Review Officer the results of the test(s) to which I have consented. I further authorize the Company to discuss the results with medical personnel / physician collecting the specimen, the testing facility, its directors, officers, agents, and employees responsible for administering the aforementioned test(s) or evaluating the results thereof and any of them herein. I also authorize the Company to discuss the results with its legal advisors and to use the test results as a defense to any legal action to which I am a party.

I further release any testing facility or any physicians who have tested me from any liability arising from a release of any and all results, written reports, medical records, and data concerning my test(s) to the appropriate Employer officials. I agree to have the results released to the Company and/or the Company's Medical Review officer.

Employee or Applicant Signature:_____ Print Name:_____ Date:_____
(Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant SS#:_____ Witness:_____ Date:_____

OR

I hereby refuse to consent to submit testing for the presence of drugs and/or alcohol.

Employee or Applicant Signature:_____ Print Name:_____ Date:_____
(Parent or Guardian Signature if Employee is a Minor)

Employee or Applicant SS#:_____ Witness:_____ Date:_____