OptaComp℠

The workers' comp affiliate of Florida's

Workers' Compensation Program for Employees and Volunteers of State of Florida Agencies and Universities

Florida Department of Financial Services
Division of Risk Management
1-800-262-4402

orientation
for injured workers

Accidents in the wokplace happen, but rest assured the Division of Risk Management and OptaComp take our responsibility to you and your employer seriously.

REPRESENTING
ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

Dear Injured Worker:

The Division of Risk Management within the Florida Department of Financial Services is responsible for providing workers' compensation benefits to injured employees or volunteers of State of Florida agencies and universities. We understand that you have been injured and want you to know we are committed to providing timely benefits to aid in your medical recovery and return to work.

We have partnered with OptaComp, the workers' compensation affiliate of Blue Cross and Blue Shield of Florida, to coordinate your related medical care. An OptaComp Registered Nurse or Licensed Practical Nurse will schedule and authorize all necessary medical appointments, answer medical related questions and assist in your return to work.

The Division of Risk Management adjuster is responsible for the determination of compensability of your claim, the payment of lost-time indemnity benefits should your work related injury cause you to miss more than forty hours of work, and reimbursement to you for medical mileage to authorized medical appointments.

Career service, SES, SMS, and other permanent State of Florida agency or university employees who sustain a disability from a work-related injury are carried in full-pay status for the initial forty hours without being required to use accrued leave. This leave may be used for continuous disability or intermittently to cover medical appointments that are directly related to the workers' compensation injury. This benefit is not given to OPS or other non permanent employees. Questions regarding the initial forty hour disability benefit should be directed to your employer.

The partnership between the Division of Risk Management and OptaComp is committed to providing the best possible service to you and your employer. Please contact your Division of Risk Management adjuster at 1-800-262-4402 if you have any questions.

Sincerely,

Denzil Weimorts
Manager, State Employees' Workers' Compensation Claims

REPRESENTING
ALEX SINK
CHIEF FINANCIAL OFFICER
STATE OF FLORIDA

Dear Injured Employee:

Your employer's insurance carrier is providing this information to you on behalf of the Employee Assistance Office of the Division of Workers' Compensation.

The Employee Assistance Office of the Division of Workers' Compensation is a state bureau within the Florida Department of Financial Services. We provide the following services:

- Serves as a resource for injured workers and employers by providing information about the workers' compensation system.
- Educates and informs injured workers, employers, carriers, health care providers, and managed care arrangements about their responsibilities under the law.
- Provides assistance in avoiding any problems or disputes regarding your claim.

Within three (3) days after receiving notice that you have been injured, the workers' compensation insurance carrier will mail you an informational brochure explaining your rights and responsibilities as well as the carrier's obligations. It contains valuable information you need to know about the workers' compensation system. You may have received the informational brochure along with this letter. You can obtain the brochure by calling us at 1-800-342-1741 or e-mailing us at: wceao@dfs.state.fl.us.

You can also visit one of our local Employee Assistance Offices to receive personal, one-on-one service. To locate the office nearest you, call the toll free 1-800 number above or visit the Division's website at: www.fldfs.com/WC/ and click on "About Us".

Sincerely,

Tanner Holloman
Director, Division of Workers' Compensation

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
Division of Workers' Compensation • Employee Assistance and Ombudsman Office
200 E. Gaines St. • Tallahassee, FL 32399-4225 • Tel. (800) 342-1741
Email wceao@fldfs.com
Affirmative Action • Equal Opportunity Employer

OptaComp℠
The workers' comp affiliate of Florida's

P.O. Box 44291
Jacksonville, FL 32231-4291
www.optacomp.com

Independent licensee of the
Blue Cross and Blue Shield Association.

Dear Injured Worker:

On behalf of OptaComp and the employer, we understand that you have been injured and want you to know we are committed to devoting all of the time and energy needed to aid in your medical recovery and return to work.

It is our role to assist you in obtaining those benefits to which you are entitled and to assist in the ongoing communication between you, your employer and the medical community. Please consider us to be your partner in the workers' compensation process.

While receiving care, you should expect:

- At all times to be treated with care, consideration, and concern
- Timely access to appropriate medical care
- Access to a Nurse Case Manager and Adjuster team that is assigned to your claim and is dedicated to supporting your needs
- We will act as your partner in the workers' compensation process
- Your telephone calls will be returned during the same business day

We are committed to providing you the very best possible service. If at any time you feel dissatisfied with the service you receive, please give us the opportunity to exceed your expectations by contacting the OptaComp management team.

Sincerely,

Jeff Close
Manager, Performance Optimization
Telephone: 800.545.6565 ext. 37814
Mobile: 407.314.8184
Fax: 407.804.4490
Email: jeff.close@bcbsfl.com

OptaComp and its parent, Blue Cross and Blue Shield of Florida,
are Independent Licensees of the Blue Cross and Blue Shield Association.
OptaComp is the formal trade name for Comp Options Insurance Company, Inc.

Table of Contents

OptaComp℠
The workers' comp affiliate of Florida's

Critical Information

Your claim is being processed under Florida Statute 440.20(4), which requires the Division of Risk Management to initiate payment of compensation while we gather information about your claim. In good faith, we may begin payment of benefits to you to ease your financial burden and to take care of your medical needs. Should it be determined for any reason that part or your entire claim will be denied, we must do so, and notify you in writing, within 120 days of the initial provision of benefits. Should your claim be denied, the Division of Risk Management will pay for all care that was authorized by us through the date of our written notice of denial to you.

Statute Of Limitations

Once you are injured at work or become aware of a workers' compensation injury, you have 30 days in which to report your injury to your employer. Generally, you have two years from the date of your injury to file a claim. Failure to report your injury within 30 days may be used as a defense against your claim regardless of the two-year statute of limitation for filing a claim. Your eligibility for benefits may also be eliminated one year from the date you last received a wage replacement check or any approved medical care/treatment.

If you are uncertain about, or would like to make sure that the information provided in this package is accurate, you are encouraged to call the following number listed below:

The Florida Department of Financial Services
Division of Workers' Compensation
Employee Assistance Office

Phone Number:
1-800-342-1741

The State of Florida, Department of Financial Services, Workers' Compensation Division, will help you with any questions you may have as a Florida injured worker, and can help resolve any issues that may arise between you, the Division of Risk Management, and OptaComp.

Employees are covered from the first day of work on the job.

Required Forms and Critical Information

All of the information in this Orientation for Injured Workers package is IMPORTANT. Please follow the steps provided and take the time to read it carefully and thoroughly.

Step 1

- Please immediately and carefully READ, SIGN, DATE AND RETURN the attached enclosed forms/documents on the next pages in the self-addressed, postage-paid envelope provided.

CHECKLIST:

❑ Acknowledgement Form - (Page 3)

- Medical Authorization Release Form
- Fraud Statement
- Receipt of the State of Florida Brochure entitled "Employee Facts - Important Workers' Compensation Information For Florida's Workers"
- Letter from the Florida Department of Financial Services/Division of Workers' Compensation
- Protected Health Information (PHI)

❑ Workers' Compensation Injured Worker Survey Form – (Page 11)

IMPORTANT - READ CAREFULLY:

- Under Florida Statute 440.105(7): An injured employee or any other party making a claim under this chapter shall provide his or her personal signature attesting that he or she has reviewed, understands, and acknowledges the following statement: "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." If the injured employee or other party refuses to sign the document attesting that he or she has reviewed, understands and acknowledges the statement, benefits or payments under this chapter shall be suspended until such signature is obtained.

Step 2

- Follow your physician's orders.
- Failure to keep scheduled appointments may risk your workers' compensation benefits.
- If you need any assistance with your medical care, please contact your Nurse Case Manager.

Step 3

- Communicate regularly with Risk Management, OptaComp and your employer.

Acknowledgement Form

OptaComp℠
The workers' comp affiliate of Florida's

ACTION REQUIRED

Please READ, SIGN, and RETURN this Acknowledgement Form in the postage-paid envelope provided in this package.

Medical and/or Hospital Authorization

- I hereby give my permission, and this is your authority to permit the Division of Risk Management, OptaComp and their designated representative to examine, make or be furnished with copies of any records or information, x-rays and x-ray reports in connection with any illness or injury requiring confinement and/or treatment by you.
- I agree that a Photostat copy of this authorization shall be considered as effective and valid as the original.
- I understand that I have the right to revoke this authorization in writing at any time.

Fraud Statement

- I understand and acknowledge that "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."

Employee Facts - Important Workers' Compensation Information For Florida's Workers

- I acknowledge that I received the enclosed copy of a brochure entitled Employee Facts - Important workers' compensation Facts for Florida's Workers' and a letter (at the beginning of this orientation package) from the Florida Department of Financial Services/Division of Workers' Compensation regarding the services provided by the Employee Assistance Office.

Protected Health Information (PHI)

- Pursuant to HIPAA, a covered entity (health care provider, etc.) can release employee's or other's protected health information (PHI) "as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault." 45 C.F.R. 164.512(l).

Print Name: _____

Signature: _____ Date: _____

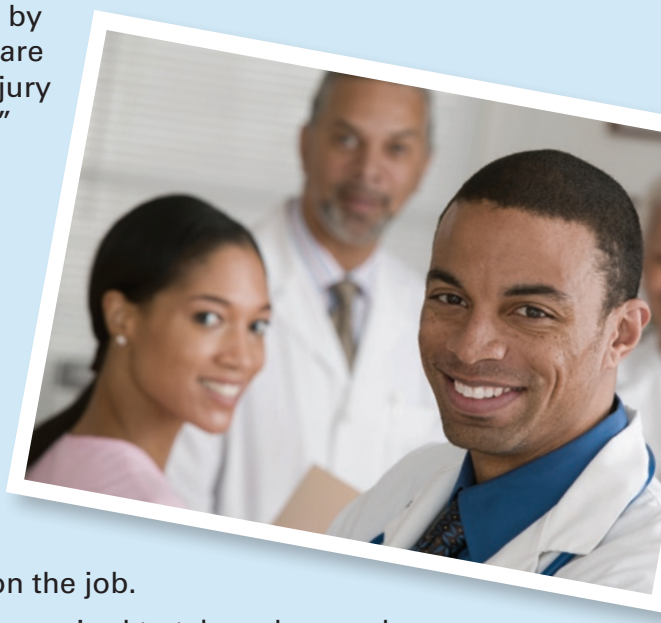
Internal Use: Affix Claim Label Here

General Information

This information is being provided to you to explain your rights and responsibilities. This booklet will explain your legal rights, according to the State of Florida, for receiving lost wages, medical care and stay at work information. Should you have any additional questions, please do not hesitate to call your adjuster at the Division of Risk Management.

What is Workers' Compensation?

PLEASE NOTE: Neither your employer nor the Division of Risk Management establish benefits allowed under the law. Workers' Compensation is regulated by the State of Florida and the law sets the benefit levels. You are protected under workers' compensation if you sustain an injury or occupational illness "arising out of the course and scope" of your employment.



Employee's Rights and Benefits

- Workers' compensation insurance coverage is provided by the employer at no cost to the injured worker.
- It will pay for all reasonable and necessary medical care if an employee gets injured at work or develops an occupational disease "arising out of the course and scope" of employment.
- Employees are covered from the first day of work on the job.
- If an employee is injured on the job, he/she may be required to take a drug and alcohol test. If he/she tests positive for alcohol or drugs at the time of injury, the injured workers' claim may be denied, and he/she may not receive benefits.
- An injured worker has the right to copies of any medical reports they request. There may be a charge of $.50 per page by the medical office for regular copies; actual costs for x-rays or non-paper documents may be more.

What is an Adjuster?

An adjuster is responsible for gathering the facts of a claim and claim decision making, as well as the authorization of benefits arising under workers' compensation claims, insurance policies, coverage agreements and service agreements.

General Information

What is a Nurse Case Manager?

A Nurse Case Manager is a Registered Nurse or Licensed Practical Nurse who will coordinate the injured workers' related medical care. The Nurse Case Manager will schedule and authorize all necessary physicians' appointments, answer medical related questions and assist an injured worker to stay at work or in some cases, return to work after treatment/care.

Lost Wage Benefits

Injured workers may be entitled to lost wages, if lost time from work is due to restrictions placed on the injured worker by his/her authorized treating physician.

The Florida Workers' Compensation Law mandates that the first seven days of disability after an injury are a waiting period. Thereafter, during the continuation of disability, the injured worker will be reimbursed lost wages at 66 2/3% of their average weekly wage not to exceed the maximum benefit established by the State.

As a Career Service, SES, or other permanent SMS State of Florida employee, if you sustain a disability due to a work related injury then you will be carried in full pay status for the initial forty hours of disability without being required to use accrued leave. Beyond the initial week of disability you may be permitted to use accrued leave to make up the difference in 100% of your salary and the amount of disability benefits paid by Risk Management. Please contact your employer for additional information.

If you have a second job, it is your responsibility to advise your adjuster as this may impact your benefit entitlement.

Stay at Work, Return to Work

Injured workers are expected to return to work immediately after medical appointments, whether in a normal capacity or in a modified manner as assigned by the authorized physician. If an injured worker refuses to return to work, he/she may lose certain workers' compensation benefits.

The employer will make every effort to provide the injured worker with work, taking into account any functional limitations assigned by the authorized treating physician. If the employer is not able to take the injured worker back within his/her restrictions, benefits will be paid until he/she locates other employment or is placed at maximum medical improvement.

OptaComp will authorize all medically necessary referrals and will make all arrangements.

General Information

Maximum Medical Improvement

When the physician finds that the injured worker is back to his/her pre-injury condition or is the best that he/she will be medically after the injury, the physician will place the injured worker at maximum medical improvement. Once an injured worker is placed at maximum medical improvement, he/she will be paid any impairment benefits due as determined by his/her level of disability, which is determined by the authorized treating physician. Impairment benefits are paid by the Division of Risk Management adjuster.

In addition, when the injured employee is placed at overall maximum medical improvement, her/she will be obligated to pay a co-payment of $10 per office visit for medical services, except for emergency care. The co-payment requirement is pursuant to Florida Statute 440.13(14)(c).

Note: Follow-up appointments must be pre-authorized by your Nurse Case Manager.

OptaComp Responsibilities

OptaComp is responsible for facilitating medical benefits to which an injured worker may be entitled. We will provide injured workers with access to medical care by making referrals to treatment centers/physicians near the injured workers normal work site. OptaComp will make every effort to ensure that licensed physicians and other licensed health care professionals provide all medical services. OptaComp will help with questions about workers' compensation and how to access medical care. We are responsible for timely payment of all workers' compensation medical benefits.

Division of Risk Management Responsibilities

The Division of Risk Management is responsible for providing workers' compensation coverage to State of Florida agencies and universities, their employees and volunteers. The Risk Management adjusters are responsible for claim decision making including determination of compensability, the provision of lost-time benefits to employees disabled from a work-related injury and the administration of other non-medical workers' compensation benefits. Risk Management partnered with OptaComp to coordinate your related medical care.

General Information

Injured Workers' Responsibilities

1. Emergency Care
    - In the event of a true emergency, call 911 or go to the nearest emergency room, then contact the employer as soon as possible.
    - The employer will call OptaComp as soon as possible after emergency care/treatment has been received.
    - OptaComp will coordinate any follow-up medical care that may be required.

2. Routine or Urgent Care
    - An injured worker must inform the employer immediately of the injury.
    - The employer will call OptaComp to get access to appropriate medical care and to pre-authorize that care.
    - The physician will provide treatment and make determinations of any future medical needs.
    - All scheduled follow-up appointments must be kept to avoid jeopardizing any workers' compensation benefits that may be due.
    - If for some reason a medical appointment cannot be kept, the Nurse Case Manager should be contacted immediately to reschedule and authorize the next appointment.

While Receiving Treatment

Once during a claim, an injured worker may request a "one-time change in physician" by calling the Nurse Case Manager and submitting the request in writing (see page 10). Upon receipt of the written request, the Nurse Case Manager will facilitate the transfer of your care to a new physician and the current doctor will be de-authorized.

At any time during treatment, a physician may refer care to a medical specialist for testing or additional services. OptaComp will authorize all medically necessary referrals and will make all arrangements.

Safety

Employees must wear and use any safety equipment required by the employer. Failure to do so could result in the reduction of workers' compensation indemnity benefits by 25%.

Hurricane Season

During any hurricane warning/watch, it is the injured workers' responsibility to ensure adequate supply of authorized medications.

The Nurse Case Manager is available to answer any questions.

MILEAGE REIMBURSEMENT

Social Security #:_____
Employee: _____
Employer: _____
Date of Accident:_____

****PLEASE COMPLETE EACH SECTION OF THIS FORM FOR EACH DAY MILEAGE REIMBURSEMENT THAT IS BEING CLAIMED.**

Claim Number: _____

NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY:	DATE(S)	ADDRESS CLAIMANT STARTED FROM	ADDRESS OF FINAL DESTINATION AFTER DR'S APPT	ROUND TRIP MILES

PLEASE DO NOT WRITE IN THIS SPACE

MILEAGE IS REIMBURSED AT $.445 CENTS PER MILE FOR TRAVEL TO/FROM AUTHORIZED MEDICAL PROVIDERS AFTER 6/30/06..

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, FS.

Mail to: Division of Risk Management
Bureau of State Employees' WC Claims
P.O. Box 8020
Tallahassee, Florida 32314-8020

Claimant's Signature: _____
Mailing Address:_____
City/State/Zip: _____
Date: _____

REV.12/2008

MILEAGE REIMBURSEMENT

Social Security #:_____
Employee: _____
Employer: _____
Date of Accident:_____

****PLEASE COMPLETE EACH SECTION OF THIS FORM FOR EACH DAY MILEAGE REIMBURSEMENT THAT IS BEING CLAIMED.**

Claim Number: _____

NAME AND ADDRESS OF PHYSICIAN OR MEDICAL FACILITY:	DATE(S)	ADDRESS CLAIMANT STARTED FROM	ADDRESS OF FINAL DESTINATION AFTER DR'S APPT	ROUND TRIP MILES

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Mail to: Division of Risk Management
Bureau of State Employees' WC Claims
P.O. Box 8020
Tallahassee, Florida 32314-8020

Claimant's Signature: _____
Mailing Address:_____
City/State/Zip: _____
Date: _____

REV.12/2008

One-Time Change of Physician Form

OptaComp℠
The workers' comp affiliate of Florida's

PLEASE COMPLETE, SIGN AND RETURN

TO: **OptaComp**
P.O. Box 44291
Jacksonville, FL 32231-4291

RE: Employer:_____

Claim #:_____

Date of Injury: _____

Current Physician: _____

Please accept this letter as my request for one-time change of physician for the accident indicated above.

The Florida Statue 440.13(2)(f) defines the injured workers rights and responsibilities as stated below:

"Upon the written request of the employee, the carrier shall give the employee the opportunity for one change of physician during the course of treatment for any one accident. Upon the granting of a change of physician, the originally authorized physician in the same specialty as the changed physician shall become de-authorized upon written notification by the employer or carrier. The carrier shall authorize an alternative physician who shall not be professionally affiliated with the previous physician within 5 days after receipt of the request. If the carrier fails to provide a change of physician as requested by the employee, the employee may select the physician and such physician shall be considered authorized if the treatment being provided is compensable and medically necessary."

By signing below, I understand and acknowledge that I am requesting my one-time change in Physician as allowed by Florida law and that I may not request another change of physician.

Print Name: _____

Signature:_____ Date: _____

OptaComp℠
The workers' comp affiliate of Florida's

PLEASE COMPLETE, SIGN AND RETURN

Survey Questions	Very Satisfied	Generally Satisfied	Generally Dissatisfied	Very Dissatisfied
OptaComp Service Experience:				
1. OptaComp offered caring solutions and seemed genuinely concerned about my work related incident. *(Examples: I felt reassured, supported, and listened to)*				
2. OptaComp handled my claim competently. *(Examples: I felt like I was in capable hands, my calls were returned timely, and the information I received was accurate)*				
3. OptaComp made sure I knew how to reach help regarding my claim. *(Examples: I was offered a local or toll-free number, information was provided on how to reach my adjuster and my nurse)*				
Initial Care for My Injury:				
4. I felt the medical examination I received took care of my medical needs. *(Examples: The examination was adequate, the physician discussed treatment options with me, gave me reassurance about my recovery, etc.)*				
5. If I did not have my own physician, I would select this physician to provide non-work related care for me.				
6. I felt the physician made a good attempt to explain his findings, conclusions and expectations about my injury. *(Examples: Physician explained my role in staying active in my recovery and my ability to stay at work or return to work. I have a good understanding of my work-related condition)*				

7. My initial care was provided by:
(please check one of the following options below)

Emergency Room_____ Urgent Care / Walk-In Facility_____ Individual Physician Office /Specialist_____

Additional Comments *(If necessary, please use additional paper)*:

Survey Completed by: Print Name: _____ Date:_____

EMPLOYEE EARNINGS REPORT

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

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

CAUTION

FAILURE OR REFUSAL OF EMPLOYEE TO COMPLETE, SIGN, AND RETURN THIS REPORT WITHIN 21 DAYS AFTER THE DATE OF RECEIPT OF THE REQUEST MAY CAUSE PAYMENT OF BENEFITS TO STOP UNTIL SUCH TIME AS THE COMPLETED FORM IS FURNISHED TO THE REQUESTING PARTY.

PLEASE PRINT OR TYPE

I. IDENTIFICATION OF PARTIES (To be completed by requesting party)

EMPLOYEE'S SOCIAL SECURITY NUMBER ✂	EMPLOYEE'S NAME (First, Middle, Last)	DATE OF ACCIDENT (Month-Day-Year)
EMPLOYEE"S ADDRESS	ACCIDENT EMPLOYER'S NAME & ADDRESS	CLAIMS-HANDLING ENTITY NAME & ADDRESS Department of Financial Services Division of Risk Management Post Office Box 8020 Tallahassee, Florida 32314-8020

II. NOTICE TO EMPLOYEE

THE WORKERS' COMPENSATION LAW REQUIRES ALL PERSONS RECEIVING OR CLAIMING BENEFITS FOR TEMPORARY DISABILITY AND/OR PERMANENT TOTAL DISABILITY TO REPORT ALL EARNINGS OF ANY NATURE TO THE EMPLOYER, INSURANCE COMPANY AND/OR DIVISION OF WORKERS' COMPENSATION. PLEASE COMPLETE THIS REPORT AND RETURN IT TO THE REQUESTING PARTY WITHIN 21 DAYS AFTER THE DATE OF YOUR RECEIPT.

TIME PERIOD TO BE REPORTED		HAVE YOU RECEIVED INCOME FROM ANY SOURCE OTHER THAN WORKERS' COMPENSATION?
FROM	**TO**	☐ YES (IF YES, COMPLETE FORM, SIGN, DATE & RETURN) ☐ NO (IF NO, SIGN, DATE AND RETURN

IF NECESSARY, ATACH ADDITIONAL EARNINGS DOCUMENTATION

III. HAVE YOU RECEIVED EARNINGS FROM ANY PERSON, FIRM OR COMPANY DURING THE TIME PERIOD IN SECTION II? ☐ YES (IF YES, COMPLETE INFORMATION BELOW) ☐ NO

PERSON/FIRM/COMPANY NAME	ADDRESS	PERIOD WORKED		TOTAL GROSS EARNINGS
		FROM	TO	

IV. DURING THE TIME PERIOD IN SECTION II, HAVE YOU BEEN SELF EMPLOYED? YES NO

BRIEFLY DESCRIBE NATURE OF BUSINESS OR SERVICE

DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED	DATES SELF-EMPLOYED		WAGES, INCOME OR BENEFITS RECEIVED
FROM	TO		FROM	TO	

V. DURING THE TIME PERIOD IN SECTION ii, HAVE YOU RECEIVED ANY SOCIAL SECURITY BENEFITS? ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

TOTAL MONTHLY SOCIAL SECURITY INCOME	AMOUNT PAID FOR YOUR DISABILITY	AMOUNT PAID FOR YOUR DEPENDENTS

VI. DURING THE TIME PERIOD IN SECTION II, HAVE YOU RECEIVED WAGES, INCOME, OR BENEFITS FROM ANY OTHER SOURCE, i.e. Unemployment Compensation Benefits, Workers' Compensation Benefits from another insurer, etc? Attach additional documentation if necessary. ☐ YES (IF YES, STATE AMOUNTS) ☐ NO

	PERIOD BENEFITS RECEIVED		TOTAL AMOUNT
SOURCE OF WAGES, INCOME OR BENEFITS	FROM	TO	

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. THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE'S SIGNATURE _____ DATE _____

VII. RETURN TO (To be completed by requesting party):

REQUESTING PARTY'S NAME	**REQUESTING PARTY'S SIGNATURE**	REQUESTING PARTY'S ADDRESS & TELEPHONE
		Florida Department of Financial Services Bureau of State Employees' WC Claims Post Office Box 8020 Tallahassee, Florida 32314-8020 (850) 413-3123
TITLE	DATE (Month-Day-Year)	

Form DFS-F2-DWC-19 (08/2004)

Important Information: Pre-injury Wages

READ THIS IF YOU HAVE BEEN RELEASED TO WORK AND YOU ARE NOT MAKING AT LEAST 80% OF YOUR PRE-INJURY WAGES

Your doctor has released you to return to work, but because of your work related accident, you have been given restrictions on the type of work you can now do. Because you have not reached maximum medical improvement (the date after which your doctor says your injury will probably not get better), you may continue receiving workers' compensation benefits approximately every two weeks if you are not able to earn at least 80% of the weekly wages you were making before your injury.

These benefits, called Temporary Partial Disability benefits, will be paid until:

1. You reach maximum medical improvement or can return to work without restrictions;
2. You receive the maximum of 104 weeks allowed by law for either Temporary Total Disability benefits, Temporary Partial Disability benefits or Training and Education Temporary Total benefits, or 104 weeks for the combined benefits; OR
3. You earn 80% or more of the weekly wages you were making at the time of your accident.

IMPORTANT: Temporary Partial Disability benefits may be stopped if:

1. You do not notify your Division of Risk Management adjuster within five (5) business days after you return to work;
2. You are not working due to your own misconduct on the job;
3. You refuse suitable employment offered to you; or
4. You do not return, if requested, Form DFS-F2-DWC-19, "Employee Earnings Report" form (page 16), as adopted in Rule 69L-3.025, F.A.C., to your Division of Risk Management adjuster within 21 days after you receive it and report the receipt of any earnings, including Unemployment Compensation or Social Security benefits. You may be asked to complete, sign and return the Employee Earnings Report form once a month.

You are to notify the Division of Risk Management immediately if you stop making at least 80% of your pre-injury weekly wages. However, if you leave your job without just cause as determined by a Judge, your temporary partial disability benefits will be paid based on the amount of money you would have earned had you not left work.

For more information about temporary partial disability benefits, please call the Employee Assistance Ombudsman Office (EAO) with the Division of Workers' Compensation at any of its local offices listed in your "Important Workers' Compensation Information for Florida Workers' brochure, or at 1 (800) 342-1741.

Enclosed Form DFS-F2-DWC-19 (see page 12)

OptaComp℠

The workers' comp affiliate of Florida's

orientation
for injured workers

Here at OptaComp we embrace diversity as the "inclusion of everyone, specifically the unique combinations of human characteristics of self and others".

Please visit us at www.optacomp.com

OptaComp and its parent, Blue Cross and Blue Shield of Florida,
are Independent Licensees of the Blue Cross and Blue Shield Association.
OptaComp is the formal trade name for Comp Options Insurance Company, Inc.

67514B-1208