

FALSE OR FRAUDULENT CLAIM WARNING

Please read the following information carefully and return the form, signed and dated within **30 days** or your benefits or payments shall be suspended until your signature is obtained as prescribed by Florida Statute 440.105 (7).

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 Florida Statute 817.234.

Worker's Compensation fraud includes, but is not limited to:

- Requesting and/or receiving temporary total, temporary partial or permanent total disability benefits while working for gain as an employee of a business, independent contractor, yourself or a business owner and not reporting that income to the insurance company.
- Making false statement and/or submitting false documentation concerning, identity, wages and/or employment.
- Misrepresenting facts concerning an industrial accident, injury or illness to your employer, your physician or the insurance company.
- Making a false statement and/or submitting false documentation concerning transportation reimbursement requests.
- Selling your personal information to third parties for use in misrepresenting facts to any medical provider or insurance company.

I certify that I, the injured worker, have reviewed, understand, and acknowledge the foregoing.

Claim Number W _____

Worker's Name _____

Worker's Address _____

Telephone _____

Social Security No. _____

Worker's Signature _____ Date _____