AUTHORIZATION AND REQUEST FOR UNEMPLOYMENT COMPENSATION INFORMATION

RECEIVED BY CLAIMS-HANDLING ENTITY

AGENCY FOR WORKFORCE INNOVATION

Unemployment Compensation
Benefit Records
Post Office Box 5750
Tallahassee, FL 32314-5750

FLORIDA DEPARTMENT OF FINANCIAL SERVICES

DIVISION OF WORKERS' COMPENSATION

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 REQUEST THE AUTHORIZATION AND RELEASE OF UNEMPLOYMENT COMPENSATION ON THE FOLLOWING PERSON

Employer's Case File No.	Employee's Name (First, Middle, Last)	
Claims-handling entity File No.	Name of Employer's Firm	Date of Accident (Month-Day-Year)

I HEREBY CERTIFY THAT I AM THE EMPLOYER OF RECORD OR THE EMPLOYER'S WORKERS' COMPENSATION INSURER, OR THEIR REPRESENTATIVE WITH WHOM A CLAIM FOR BENEFITS UNDER CHAPTER 440 F.S. HAS BEEN MADE.

NAME AND ADDRESS OF EMPLOYER/CLAIMS-HANDLING ENTITY (REQUESTOR) SUMMIT CLAIMS CENTER P.O. BOX 2928 LAKELAND, FL 33806-2928 1-800-282-7644 *TO INSURE DELIVERLY, PLEASE ENCLOSE A SELF-ADDRESSED STAMPED ENVELOPE*	Signature of Requestor Name of Requestor (please print) Title of Requestor

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF UNEMPLOYMENT COMPENSATION INFORMATION

NOTE: Section 443.1715, F.S., requires you to furnish this authorization for release of unemployment compensation information for a claimant who has a worker's compensation claim pending or is receiving compensation benefits.

The Florida Worker's Compensation Act provides that worker's compensation benefits shall be reduced by the amount of the unemployment compensation received pursuant to Section 440.15(10), F.S. To allow determination of the proper amount of workers compensation, I hereby authorize release of unemployment compensation information relative to my account.

THIS AUTHORIZATION IS VALID FOR A PERIOD OF 12 MONTHS FROM THE DATE SIGNED.

EMPLOYEE'S SIGNATURE	DATE SIGNED: (Month-Day-Year)

UNEMPLOYMENT COMPENSATION INFORMATION (To be completed by the Agency for Workforce Innovation)

HAS EMPLOYEE FILED FOR UNEMPLOYMENT COMPENSATION? ☐ YES ☐ NO

IF YES, WHAT IS THE STATUS OF THE CLAIM?

- ☐ Eligible (See attached record of payments)
- ☐ Denied
- ☐ Pending (Re-submit request in 90 days)
- ☐ Records have been officially purged

COMMENTS:

DATE: (Month-Day-Year)	OFFICIAL SIGNATURE	TITLE