Fraud Statement Acknowledgement Form

Injured Worker _____ Date of Injury _____

Employer _____ Current Date _____

The State of Florida requires that we provide this document for you to review, understand and acknowledge.

Fraud Statement Under Section 440.105(7) of the Florida Workers' Compensation Law:

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.

Acknowledgement:

I have reviewed and understand the fraud statement above. I have asked questions about anything that was not clear to me. I am satisfied with the answers I have received. I understand that the refusal to sign this may result in the suspension of benefits or payments.

Signature _____

Printed Name _____ Date _____

Fax the completed form to us at 844-761-8402 or email it to claims@omahanational.com.