AmTrust North America
An AmTrust Financial Company

Georgia
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

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AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?

- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.

We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.

Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	☐ Male ☐ Female	Birthdate	Phone Number	Employee E-mail
Mailing Address		City	State	Zip Code

EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg.,etc.)
Mailing Address		Phone Number	Employer FEIN
City	State / Zip Code	Employer E-mail	

INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #
CLAIMS OFFICE	Name	Claims Office FEIN # / Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Mailing Address	City / State / Zip Code	

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month
Insurer Type Code ☐I – Insurer ☐S-Self-insurer ☐Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ☐ am ☐ pm	County of Injury	Date Employer had knowledge of Injury	Enter First Date Employee Failed to Work a Full Day
Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No	Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs	Hospital / Treating Facility (Name and Address)	If Returned to Work, Give Date: / Returned at what wage per Week / If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type)	Telephone Number	Date of Report

☐ B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum

Previously Medical Only ☐ Yes ☐ No

Average Weekly Wage: $ _____ Weekly benefit: $ _____ Date of disability:

Date of first Payment: _____ Compensation paid: $ _____ or Date salary paid: _____ Penalty paid: $ _____

BENEFITS ARE PAYABLE FROM _____ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of _____ % to _____ for _____ weeks.

UNTIL _____ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

☐ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

☐ D. MEDICAL ONLY INJURY (No indemnity benefits are due and/or have NOT been controverted.)

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone Number	E-mail	

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.

2. Complete Section A of this Form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY**.
   Do not send this form to the State Board of Workers' Compensation. If you need additional help, call your insurance company or self-insurer claims office.

3. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

B. NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct insurance company and their SBWC ID number.

Complete Section B, C, or D and file with the Board and send a copy of both sides of the Form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury, or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

C. NOTICE TO EMPLOYEE

This form is provided for your information only.

If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a Form WC-14 Notice of Claim within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For information or assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free: 1-800-533-0682
Atlanta: (404) 656-3818

https://sbwc.georgia.gov

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE		Mailing Address		
E-mail Address		City	State	Zip Code
EMPLOYER	Name	Mailing Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER	Name			
CLAIMS OFFICE	Name	Mailing Address		
SBWC ID #	Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

☐ 13 Weeks of Employee's Wages ☐ 13 Weeks of a Similar Employee's Wages ☐ Full Time Weekly Wage of Injured Employee: $_____

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
			Total							
			Average Weekly Earnings							

C. SCHEDULED DAYS OFF

REQUIRED TO COMPLETE: ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun ☐ No Off Days

D. REMARKS

REMARKS:

Type or Print Name	Signature	Date
E-mail Address		Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF CHANGE OF TPA / SERVICING AGENT

The purpose of this form is to notify the Board of a change in the TPA/Servicing Agent. **This form must be completed by the Insurer, Self-Insurer or Group Fund no later than 30 days prior to the effective date of the change** and sent to the State Board of Workers' Compensation, 270 Peachtree Street NW, Atlanta, GA 30303-1299.

A TPA / Servicing Agent MUST be licensed by the Office of the Commissioner of Insurance pursuant to O.C.G.A. §33-23-100.

A. INSURER/SELF-INSURER/GROUP FUND

Name of Insurer / Self-Insurer / Group Fund	SBWC ID #	FEIN #	
Mailing Address	City	State	Zip Code
Corporate Contact Person	Title	Signature of Corporate Contact	
Date	Phone Number	E-mail address	

B. NAME OF CLAIMS OFFICE BEING TERMINATED

Name of Claims Office Being Terminated	Phone Number	FEIN #	
Mailing Address	City	State	Zip Code

C. NOTICE OF REPLACEMENT CLAIMS OFFICE

Name of New Claims Office			FEIN #
Mailing Address	City	State	Zip Code
Contact Name for Claims Handling	Title	Phone Number (toll-free if out-of-State of Georgia)	Fax Number
Primary E-mail Address for E-mail Notification	Secondary E-mail for E-mail Notification		**Effective Date of Replacement**

D. NOTICE OF ADDITIONAL CLAIMS OFFICE

The above-named Insurer / Self-Insurer / Group Fund has **OBTAINED** the services of the following claims office, as an additional claims office for the administration of workers' compensation claims.

Name of Additional Claims Office			FEIN #
Mailing Address	City	State	Zip Code
Contact Name for Claims Handling	Title	Phone Number (toll-free if out-of-State of Georgia)	Fax Number
Primary E-mail Address for E-mail Notification	Secondary E-mail for E-mail Notification		**Effective Date of Addition**

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Complete section A, B and C to notify the Board when a claims office/claims office address is being terminated and replaced.
Complete section A and D to notify Board when an additional claims office/claims office address is being added.
Complete section A, B C and D to notify Board when a claims office is being terminated, replaced and an additional claims office is being added.

Section A

Insurer/Self-Insurer/Group Fund (all fields are mandatory in section A)

1. Name of insurer/self-insurer/group fund **(do not use acronyms)**
2. SBWC ID number (five digit number) – **(Not the five digit NACI number)** see our website www.sbwc.georgia.gov/sbwc-id to verify your number
3. FEIN number for the insurer/self-insurer/group fund
4. Mailing address, city, state, zip code
5. Corporate contact person
6. Title
7. Signature of corporate contact
8. Date the form is being completed
9. Phone number
10. E-mail address – this will be used by the Board for notifications/legal notices and may be given to the public

Section B

Name of Claims Office Being Terminated (mandatory when completing section C)

1. Name of claims office being terminated
2. FEIN # of the claims office being terminated
3. Mailing address, city, state, zip code of the claims office being terminated

Section C

Notice of Replacement of Claims Office (mandatory when completing section B)

1. Name of the new claims office replacing the claims office in Section B
2. FEIN number of the claims office
3. Mailing address, city, state and zip code of the office that will handling the claims - this is the address that will be used by the Board for notifications
4. Contact name for claims handling/title – this is the person the Board will contact if needed
5. Phone number – this should be a local or a toll free number **(remember this is the contact phone number given to the public)**
6. Fax number
7. Primary E-mail address – this will be used by the Board for notifications/legal notices and will be given to the public
8. Secondary e-mail – if applicable – will receive same notification/legal notices as primary
9. Effective date of the replacement

Section D

Notice of Additional Claims Office

1. Name of the claims office being added to list of authorized claims offices for the insurer/self-insurer/group fund
2. FEIN number
3. Mailing address, city, state and zip code – this is the address that will be used by the Board for notifications
4. Contact name for claims handling/title – this is the person the Board will contact if needed
5. Phone number – this should be a local or a toll free number **(remember this is the contact phone number given to the public)**
6. Fax number
7. E-mail address – this will be used by the Board for notifications/legal notices and given to the public
8. Secondary e-mail – if applicable – will receive same notifications/legal notices as primary
9. Effective date of the addition

WC-207 AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

AUTHORIZATION AND CONSENT TO RELEASE MEDICAL INFORMATION

Instructions: This form shall not be filed with the Board, unless otherwise requested.

TO:		
Print Name and Title		
Address		
City	State	Zip Code

RE: Employee / Patient		
Last Name	First Name	M.I.
Date of Injury	Birthdate	

This document authorizes the release of only the medical information as provided below. The above-stated entity, facility or medical practitioner is authorized to release medical information to

_____

in accordance with applicable State and Federal laws.

The information covered by this Authorization and Consent to Release is that authorized by O.C.G.A. §34-9-207 which reads as follows:

(a) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury arising from the incident that the employee has had with any physician, including, but not limited to, communications with psychiatrists or psychologist. This waiver shall apply to the employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Notwithstanding any other provision of law to the contrary, when requested by the employer, any physician who has examined, treated, or tested the employee or consulted about the employee shall provide within a reasonable time and for a reasonable charge all information and records related to an examination, treatment, testing, or consultation concerning the employee.

(b) When an employee has submitted a claim for workers' compensation benefits or is receiving payment of weekly income benefits or the employer has paid any medical expenses, the employee, upon request, shall provide the employer with a signed release for medical records and information related to the claim or history or treatment of injury arising from the incident, including information related to the treatment for any mental condition or drug or alcohol abuse and to such employee's medical history with respect to any condition or complaint reasonably related to the condition for which such employee claims compensation. Said release shall designate the provider to whom the release is directed. If a hearing is pending, any release shall expire on the date of the hearing.

(c) If the employee refuses to provide a signed release for medical information as required by this Code section and, in the opinion of the Board, the refusal was not justified under the terms of this Code section, then such employee shall not be entitled to any compensation at any time during the continuance of such refusal or to a hearing on the issues of compensability arising from the claim.

Federal regulations (42 CFR Part 2), and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 45 CFR 164.512(l) which reads as follows: *"The covered entity may disclose protected health information 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 illnesses or injury without regard to fault."* Anyone who receives information under this authorization receives the same under all limitations set forth in Federal and State law regarding further dissemination of such information.

This release shall expire in 180 days or upon written notice of revocation by the patient. If a hearing is pending, this release shall remain in effect until the hearing and shall expire on the date the hearing is held.

Employee / Patient Signature	**Date**

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

ATTENTION EMPLOYER

POSTED PANEL OF PHYSICIANS:

Georgia law REQUIRES you to post a list of physicians in prominent places where all employees will see the list. (The panel will be emailed to you.)

If you will take the time to have all current and new employees initial and date a copy of the posted panel, you will prevent an employee and/or their attorney from later alleging they did not know about the panel and that you were not "in compliance" with Georgia law. An attorney can use this argument to get your employee switched to a physician of "their" choice, who may not have the same "return to work" philosophy as the panel physicians you trust.

Should you have any questions concerning the enclosed material, or if we can be of assistance, please do not hesitate to contact our office. Thank you again for your business. We look forward to our continued partnership.

Sincerely yours,

THE CLAIMS DEPARTMENT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ **INITIAL PAYMENT** ☐ **RE-COMMENCE** ☐ **SUSPEND** ☐ **AMENDMENT:** ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE		**EMPLOYER**	Name		
Mailing Address		Mailing Address			
City	State / Zip Code	City		State	Zip Code
Employee E-mail		Employer E-mail			
INSURER/ SELF-INSURER	Name	Insurer/Self-Insurer File #	Phone Number		
CLAIMS OFFICE	Name	Claims Office E-mail	State	Zip Code	
SBWC ID#	Mailing Address	City	State	Zip Code	

B. INCOME BENEFITS

Benefits are being paid to this employee at the rate of _____ *per week based on an average weekly wage of $ _____

payable from _____ / _____ / _____ for:

☐ Temporary Total Disability

☐ Temporary Partial Disability

☐ Permanent Partial Disability of _____ % to _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

Date of Disability _____

The date of the first check is, _____ , the amount is $ _____ , or date salary was paid _____ and this:

☐ Does not include a penalty

☐ Does include a _____ % penalty in the amount of $ _____ .

***File Form WC-6, Wage Statement, if weekly benefit is less than maximum.**

C. SUSPENSION OF BENEFITS

Benefits will be suspended on _____ because:

☐ 1.) Employee returned to work on _____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on _____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on _____ with restrictions from the authorized treating physician at reduced pay of $ _____ per week and temporary partial disability benefits are shown in Part B above.

☐ 4.) Employee was able to return to work on _____ without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)).

☐ 5.) The employee had undergone a change in condition pursuant to O.C.G.A. § 34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above.

☐ 6.) The employee has been offered suitable employment pursuant to O.C.G.A. § 34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. **A copy of the Form WC-240 is attached**.

☐ 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid.

☐ 8.) The entire permanent partial disability benefit has been paid.

☐ 9.) The maximum of temporary partial disability payments has been paid.

☐ 10.) This claim is being controverted within sixty days of the due date of first payment. **File the Form WC-3 simultaneously and send a copy to the employee**.

☐ 11.) Other:

Insurer/Self-Insurer Type or Print Name	Signature	Date
Phone Number	E-mail	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. RIGHT TO HEARING

If your benefits have been suspended and you believe that benefits were suspended incorrectly, you should request a hearing by sending Form WC-14 to the State Board of Workers' Compensation at the address below. If you need a Form WC-14, please contact the State Board of Workers' Compensation at the phone numbers listed below or visit the website.

STATE BOARD OF WORKERS' COMPENSATION
270 PEACHTREE STREET, N.W.,
ATLANTA, GEORGIA 30303-1299
404-656-3818
or: 1-800-533-0682
https://sbwc.georgia.gov

B. OUTLINE OF INCOME BENEFITS

In addition to paying your medical expenses for an injury at work, the employer will pay you for part of your lost wages if you are disabled from work for more than seven (7) calendar days because of your work-related injury.

TEMPORARY TOTAL DISABILITY (TTD)

O.C.G.A. § 34-9-261: IF YOU ARE NOT ABLE TO WORK AT ALL because of your injury, your employer/insurer must pay:

- 2/3 of your average weekly wage with a maximum of $800 per week if your date of accident was on or after July 1,2023 and a maximum of $725 per week if your date of accident was on or after July 1,2022. A minimum of $50.00 per week, or your actual weekly wage if less than $50.00 per week

- If your accident occurred on or after July 1, 1992, and if your injury is not catastrophic, you are not entitled to this type of benefit for more than 400 weeks. Furthermore, your benefits may be reduced to those allowed by O.C.G.A. §34-9-262 under certain circumstances after you have been released to return to work with limitations or restrictions.

TEMPORARY PARTIAL DISABILITY (TPD)

O.C.G.A. § 34-9-262: IF YOU MUST WORK FOR LOWER WAGES because of your injury at work, your employer/insurer will pay:

- 2/3 of your wage loss (the difference between what you make after your injury and what you made before) with a maximum of $533 per week if your date of accident was on or after July 1, 2023 and a maximum of $483 per week if your date of accident was on or after July 1,2022 for a maximum of 350 weeks from the ate of accident.

PERMANENT PARTIAL DISABILITY (PPD)

O.C.G.A. § 34-9-263: IF YOU LOST A PART OR MEMBER OF YOUR BODY or lose the use of a member (such as arm, finger, eye, etc.), you will first receive benefits described above during disability, and then upon return to work or otherwise becoming ineligible for TTD or TPD benefits, you will receive payment for permanent partial disability for a certain number of weeks, based on the percentage of your loss. Multiply the permanent partial disability (%) by the maximum number of weeks listed below to determine the number of weeks you will receive PPD benefits. For example, for a 15% permanent partial disability to an arm, multiply 15% times 225 weeks. The answer of 33.75 represents the number of weeks you will receive income benefits.

Bodily Loss	Maximum Weeks
Arm	225
Leg	225
Hand	160
Foot	135
Thumb	60
Index Finger	40
Middle Finger	35
Ring Finger	30
Little Finger	25
Great Toe	30
Any toe other than great toe	20
Loss of hearing, traumatic	
One ear	75
Both ears	150
Loss of vision of one eye	150
Disability to the body as a whole	300

In all cases arising under the Workers' Compensation Law, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, Fifth Edition, published by the American Medical Association.

O.C.G.A. § 34-9-220: The employer is not required to pay benefits for the first seven (7) calendar days you miss work because of your injury, unless you miss 21 consecutive days because of your injury.

O.C.G.A. § 34-9-221: If income benefits are paid late, the employer/insurer will pay you a 15% penalty on all accrued benefits. If benefits are paid late after an award has been issued, the employer/insurer will pay you a 20% penalty.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

☐ **COMMENCE** ☐ **SUSPEND**

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

Name of Claimant / Conservator

Mailing Address	City	State	Zip Code

EMPLOYER	Name	**INSURER/ SELF-INSURER**	Name
Address		**CLAIMS OFFICE**	Name
		SBWC ID	Insurer/Self-Insurer File #
		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
Employer E-mail	Phone Number	Claims E-mail	Phone Number

B. DEATH BENEFITS

☐ 1. Benefits will be paid at the rate of $ _____ *per week based on an average weekly wage of $ _____ ,

Payable from _____. The date of the first check is _____ , the amount is $ _____ ,

And this ☐ does not / ☐ does include a _____ % penalty in the amount of $ _____ . The date of death was _____ .

***File Form WC-6, Wage Statement, if weekly benefit is less than the maximum**

☐ 2. Benefits will be suspended on _____ because:

C. TOTAL DEPENDENTS

(Use additional sheets if required)

NAME	ADDRESS	PHONE NUMBER	BIRTHDATE	RELATIONSHIP

D. PARTIAL DEPENDENTS

(Complete only when there are no total dependents. Use additional sheets if required)

NAME	ADDRESS	PHONE NUMBER	BIRTHDATE	RELATIONSHIP

E. NO DEPENDENTS

☐ (Attach check and mail to the State Board of Workers' Compensation)

☐ This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

Type or Print Name	Signature	Date

E-mail	Phone Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. OUTLINE OF BENEFITS

DEATH BENEFITS

O.C.G.A. § 34-9-265: If an EMPLOYEE IS INJURED AT WORK AND DIES AS A RESULT, his or her DEPENDENTS receive:

- Medical expenses for the deceased's last injury.
- Up to $7,500 for funeral expenses.
- 2/3 of the deceased's average weekly wage with a maximum of $800 per week for accidents on or after July 1, 2023, and a maximum of $725 per week for accidents on or after July 1, 2022.
- A minimum of $50.00 per week, or the actual weekly wage if less than $50.00 per week.

If the surviving spouse is or becomes the SOLE DEPENDENT within the first year following the death of the employee, the amount of weekly benefits the spouse alone will be entitled to the maximum allowed at the time of injury.

Compensation provided by this code section is PAYABLE ONLY TO DEPENDENTS and ONLY DURING DEPENDENCY.

If there is MORE THAN ONE DEPENDENT, weekly benefits will be apportioned among the dependents.

DEFINITION OF DEPENDENT

O.C.G.A. § 34-9-13: The following are some of the persons who may receive benefits:

A SURVIVING SPOUSE who had not voluntarily abandoned the deceased at the time of the accident resulting in death. Dependency shall terminate upon remarriage or cohabitation in a meretricious relationship.

UNMARRIED CHILDREN (including stepchildren, adopted children, and posthumous children) under 18 years of age (under 22 if a full-time student in a post-secondary institution of higher learning) or incapable of self-support.

PARTIAL DEPENDENTS - Persons partially dependent are eligible only if there are no total dependents.

NO DEPENDENT DEATH CASES

Rule 265: The insurer or self-insurer in no-dependency death cases, shall pay to the State Board of Workers' Compensation the amount set forth in Code Section 34-9-265(b).

B. RIGHT TO HEARING

If your benefits as a dependent have been suspended and you believe that benefits were suspended incorrectly, you should request a hearing by sending Form WC-14 to the State Board of Workers' Compensation at the address below. If you need a Form WC-14, please contact the State Board of Workers' Compensation at the phone numbers listed below or visit the website.

STATE BOARD OF WORKERS' COMPENSATION
270 PEACHTREE STREET, N.W.,
ATLANTA, GEORGIA 30303-1299
404-656-3818
or: 1-800-533-0682
https://sbwc.georgia.gov

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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WC-25 APPLICATION FOR LUMP SUM / ADVANCE PAYMENT

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

APPLICATION FOR LUMP SUM / ADVANCE PAYMENT

Check only one: ☐ **APPLICATION** ☐ **OBJECTION**

When you receive this completed form, you must file any objection with the Board within 15 days of the date on the certificate of service (O.C.G.A. § 9-11-6(e)). If no response is received within the 15 day period, the Board will assume that the request is unopposed. Send to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299

Board Claim No.	Claimant Last Name	Claimant First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address		
	Phone Number	City	State	Zip Code

B. APPLICATION OR OBJECTION

SELECT ONE OF THE FOLLOWING THREE OPTIONS:

☐ The employer/insurer agrees to this lump sum/advance. Complete sections C, D and F only.

☐ The claimant requests a lump sum/advance and the employer/insurer does not agree to this lump sum/advance request. Complete sections D, E, F and attach all applicable documents.

☐ This is an objection to a lump sum/advance filed by the claimant. Complete section F and attach documents in support of objection.

C. AGREEMENT

☐ The employer/insurer agrees to advance $ _____, subject to a credit, as noted above, including credit for interest at 5% per annum, unless otherwise agreed to and allowed by law. Sign below if agreed to.

Employer/Insurer	SBWC ID # (five digit no.)	Phone Number	E-mail

Signature of Employer/Insurer	Title	Date

D. AFFIDAVIT

☐ Weekly income benefits have been paid to the claimant for 26 or more weeks.

☐ The claimant would like a lump sum payment of all remaining income benefits. The claimant understands that benefits will be commuted at 5% interest per annum.

☐ The claimant would like an advance payment of a part of remaining income benefits in the amount of the $ _____. This advance will be repaid by:

- ☐ Credit to be taken when PPD is commenced (an actual or projected PPD rating must be attached) or upon settlement.
- ☐ Reducing the amount of weekly benefits by $ _____ (a current medical report must be attached).

The claimant is: ☐ Married ☐ Single ☐ Divorced ☐ Separated

The claimant has _____ dependents. Their names, ages and relationships to the claimant are:

The claimant will use this money for the following: (list the specific bills or purchases for which you need the money)

☐ The claimant hereby authorizes his/her attorney to receive a lump sum payment of $ _____ (not to exceed $500.00 or 25% of advance, whichever is less, unless specifically authorized by the Board).

☐ The claimant's attorney is waiving any claim for attorney's fees on this advance.

☐ I state under oath that all of the information is correct on both pages of this document, and that all additional information requested is attached.

Signature of Claimant

Sworn to and subscribed before me this _____ day of _____ (Month) / _____ (Year) .

Notary Public _____ My Commission Expires: _____ (Month) / _____ (Year)

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

E. STATEMENT OF MONTHLY EXPENSES AND INCOME

Attach a current medical report (completed within the last 60 days) stating your physical status, extent and duration of disability, and permanent disability rating. Also attach a copy of past due bills, a copy of estimates on any matter for which you are requesting this payment, if applicable, and other relevant documents, or your request will be denied.

EXPENSES	List Expenses per month	List all past due amounts
Housing (Rent or Mortgage Payment)	$	$
Groceries	$	$
Clothing	$	$
Child Care Expenses	$	$
Medical and Dental (Not Workers' Comp. Related)	$	$
School Expenses	$	$
Utilities (Gas, Electricity, Water, Telephone)	$	$
Loans for Car, Furniture, etc.		
Date/Loan / Name of Creditor / Balance Due	$	$
Date/Loan / Name of Creditor / Balance Due	$	$
Date/Loan / Name of Creditor / Balance Due	$	$
OTHER EXPENSES		
TOTAL EXPENSES	$	$

INCOME		
Claimant's Workers' Compensation Benefits	$	$
Social Security Payment of Claimant	$	$
Other Income of Claimant	$	$
Income of Spouse	$	$
Income of Other Family Members Living with Claimant	$	$
TOTAL INCOME		

F. CERTIFICATE OF SERVICE

☐ I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date.

NOTE: Good faith effort to resolve issues means employer/insurer have had an opportunity to agree to advance before the request was submitted to the Board.

☐ I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation and to all parties and counsel in this claim.

This _____ day of _____ / _____
(Month) (Year)

Signature of Claimant or Attorney	E-mail	GA Bar Number

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE

County of Injury	Birthdate	Occupation

Mailing Address	Treating Physician

City	State	Zip Code	Physician's Specialty

Phone Number	E-mail	Diagnosis – Secondary Condition

EMPLOYER

Name	Mailing Address

City	State	Zip Code

Phone Number	E-mail

INSURER/ SELF-INSURER

Name

CLAIMS OFFICE

Name	Mailing Address

City	State	Zip Code

SBWC ID# (five-digit no.)	Insurer/Self-Insurer File #

Phone Number	E-mail

ATTORNEY FOR EMPLOYEE/ CLAIMANT

Name	Mailing Address

City	State	Zip Code

Phone Number	E-mail

ATTORNEY FOR EMPLOYER/ INSURER

Name	Mailing Address

City	State	Zip Code

Phone Number	E-mail

OTHER PARTY

Name	Mailing Address

Phone Number	E-mail	City	State	Zip Code

CURRENT SUPPLIER

Name	Reg. No.	Mailing Address

City	State	Zip Code

Phone Number	E-mail Address

PROPOSED SUPPLIER

Name	Reg. No.	Mailing Address

City	State	Zip Code

Phone Number	E-mail Address

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

B. NOTICE OF REHABILITATION REQUEST

This section must be completed to request an initial appointment, request rehabilitation be reopened, request a change of supplier.

☐ INITIAL APPOINTMENT	Number of day from date of injury	Supplier Name	Registration No.

* If the employer / insurer request initial appointment of a supplier for an employer with a date of injury of 7/1/92 or later, the claim will automatically be accepted as catastrophic in nature, absent an objection from the employee. An Administrative Decision will be issued.

☐ REOPEN REHABILITATION	Date of Previous Closure	Supplier Name	Registration No.

☐ CHANGE OF SUPPLIER	FROM	Supplier Name	Registration No.
	TO	Supplier Name	Registration No.

C. REASON FOR REQUEST

Please complete for all requests. Use a second sheet if needed. Include copies of appropriate documents.

Do all parties agree to this request? ☐ Yes ☐ No

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

D. CERTIFICATE OF SERVICE

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Signature	Representing: ☐ Employee ☐ Employer / Insurer	Phone Number	
Company / Firm Name	Mailing Address		
E-mail Address	City	State	Zip Code

E. OBJECTIONS, TWENTY (20) DAY NOTICE

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

If a rehabilitation supplier is assigned, the employer/insurer is required to provide copies of all available medical narratives and other supporting documentation.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REHABILITATION TRANSMITTAL FORM

Is this case applicable for Kid's Chance scholarships? ☐ **Yes** ☐ **No** If yes, submit application to Kid's Chance, Inc.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Birthdate	Catastrophic Injury? ☐ Yes ☐ No	Occupation
Mailing Address			Diagnosis & Functional Restrictions	
City	State	Zip Code	Initial Plan ☐ Yes ☐ No	
Phone Number	E-mail		New Plan Expectation Date:	Date Last plan Submitted:
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name
Mailing Address			**CLAIMS OFFICE**	Name
			Mailing Address	
City	State	Zip Code	City	State / Zip Code
			SBWC ID# (five digit no.)	Insurer/Self-Insurer File #
Phone Number	E-mail		Phone Number	E-mail
ATTORNEY FOR EMPLOYEE/ CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/ INSURER**	Name
Mailing Address			Mailing Address	
City	State	Zip Code	City	State / Zip Code
Phone Number	E-mail		Phone Number	E-mail
OTHER PARTY	Name		Mailing Address	
E-mail	Phone Number		City	State / Zip Code

B. REASON FOR REPORT

- ☐ As Directed by the Board
- ☐ 90-Day Report for Catastrophic Case
- ☐ Non-Catastrophic Medical Care Report
- ☐ Preparing for a Rehabilitation conference
- ☐ Other (Specify):

C. ATTACHMENTS

(You must attach all appropriate documents not previously submitted)

- ☐ Initial Rehabilitation Report
- ☐ Rehabilitation Progress Reports
- ☐ Medical / Therapy Reports
- ☐ Physical Capacity Evaluation Reports
- ☐ Psychological Evaluation Reports
- ☐ Vocational Evaluation Reports
- ☐ Other (Specify):
- ☐ Labor Market Survey
- ☐ Job Analysis
- ☐ Release to Return to Work
- ☐ Training Progress Reports
- ☐ Transferable Skills Analysis

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

D. SUMMARY

(Please provide a concise statement of activity, progress and recommendations)

E. CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Signature		Registration No.		
Rehabilitation Supplier Name	Phone Number	Mailing Address		
E-mail Address		City	State	Zip Code

F. APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent objections within 20 days of the date sent, the rehabilitation request is approved effective the date of the Certificate of Service. No further correspondence will be issued by the Board.

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the Georgia State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

INDIVIDUALIZED REHABILITATION PLAN

Is this case applicable for Kid's Chance scholarships? ☐ Yes ☐ No If yes, submit application to Kid's Chance, Inc.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Birthdate	Catastrophic Injury? ☐ Yes ☐ No	Occupation
Mailing Address			Diagnosis & Functional Restrictions	
City	State	Zip Code	Initial Plan ☐ Yes ☐ No	
Phone Number	E-mail		New Plan Expectation Date:	Date Last plan Submitted:
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name
Mailing Address			**CLAIMS OFFICE**	Name
			Mailing Address	
City	State	Zip Code	City	State / Zip Code
			SBWC ID# (five digit no.)	Insurer/Self-Insurer File #
Phone Number	E-mail		Phone Number	E-mail
ATTORNEY FOR EMPLOYEE/ CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/ INSURER**	Name
Mailing Address			Mailing Address	
City	State	Zip Code	City	State / Zip Code
Phone Number	E-mail		Phone Number	E-mail
OTHER PARTY	Name			
Mailing Address				
City	State	Zip Code		
Phone Number	E-mail			

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

B. PLAN INFORMATION

(Please check the appropriate blocks)

TYPE OF PLAN:

- ☐ Medical Care Coordination (Catastrophic Cases Only)
- ☐ Independent Living
- ☐ Extended Evaluation
- ☐ Vocational Services (select one)
  - ☐ RTW / Same Employer
  - ☐ Job Modification
  - ☐ Graduated
  - ☐ Placement On-the-Job
  - ☐ Training Formal
  - ☐ Training Self-Employment

The Following Documentation is Submitted for Plan Approval:

- ☐ Initial Rehabilitation Report
- ☐ Pain / Psychological Reports
- ☐ Rehabilitation Narrative Reports
- ☐ Physicians' Approval of Job
- ☐ Job Analysis at Time of Injury
- ☐ Transferable Skills Analysis
- ☐ Summary of Labor Market Survey
- ☐ Medical Narrative Report
- ☐ Release to RTW
- ☐ Physical Restrictions
- ☐ Physical Capacities
- ☐ Analysis of Offered Job
- ☐ Vocational Evaluation
- ☐ Other:

Give a statement (individualized to this case) as to why services of a rehabilitation supplier are needed:

State Specific Problems	State Specific Goals

C. COMPLETE THIS PART FOR CHECKED VOCATIONAL SERVICES

1. State Reasons for Type of Plan Selected:

2. Complete Work and Wage Information:

Average Weekly Wage at Time of Injury $ _____ or per Hour _____ Anticipated Wages $_____ per Week

Wage Loss $ _____ Hours Worked per Week at Time of Injury _____

☐ Proposed Full Time Work ☐ or Part Time Work

3. State Occupational Objectives:

4. List Educational / Vocational Background:

5. Occupational Objectives Determined by: (At least one)

☐ Transferable Skills		☐ Vocational Evaluation	
Date	Determined By	Date	Evaluator

☐ Summary of Vocational Evaluation (Please attach report)

☐ Summary of Labor Market Survey (Please attach report)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

D. SERVICES AND RESPONSIBILITIES REQUIRED TO MEET GOALS

(Attach additional pages as needed)

State Services/Responsibilities	Initiation Date	Completion Date	Estimate Cost	Payer
		Total Cost of Proposed Plan:		

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

E. CERTIFICATE OF SERVICE

☐ I certify that I have discussed this plan with the employee and other parties to the case and have sent copies on

_____ / _____ / _____ to the following parties at the current addresses above.
Month Day Year

Signature		Registration No.		
Rehabilitation Supplier Name	Phone Number	Address		
E-mail Address		City	State	Zip Code

F. APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

Absent objection within 20 days of the date sent, the rehabilitation request is approved effective the date of the Certificate of Service. No further correspondence will be issued by the Board.

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the Georgia State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR REHABILITATION CLOSURE

Submitted by: ☐ Claimant ☐ Employer / Insurer ☐ Supplier

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Birthdate	Catastrophic Injury? ☐ Yes ☐ No
Mailing Address			Occupation
City	State	Zip Code	Phone Number / E-mail

Fill out information in Section 2 and check appropriate status in Section 3 for return to work cases. If not returned to work, check appropriate status in Section 4. Record costs in Section 5.

EMPLOYER	Name	**INSURER/SELF-INSURER**	Name
Mailing Address		**CLAIMS OFFICE**	Name
			Mailing Address
City / State / Zip Code		City / State / Zip Code	
		SBWC ID# (five digit no.)	Insurer/Self-Insurer File #
Phone Number	E-mail	Phone Number	E-mail

ATTORNEY FOR EMPLOYEE/ CLAIMANT	Name	**ATTORNEY FOR EMPLOYER/ INSURER**	Name
Mailing Address		Mailing Address	
City / State / Zip Code		City / State / Zip Code	
Phone Number	E-mail	Phone Number	E-mail

OTHER PARTY	Name	**REHABILITATION SUPPLIER**	Name	Registration No.
Mailing Address		Mailing Address		
City / State / Zip Code		City / State / Zip Code		
Phone Number	E-mail Address	Phone Number	E-mail Address	
Do all parties agree to this closure?		☐ Yes	☐ No	

B. RETURN TO WORK INFORMATION

Employer's Business Name				Mailing Address		
Supervisor's Name		Phone Number				
Job Title		Employment Date				
Previous Weekly Wage	Previous Hours per Week	Present Weekly Wage	Present Hours per Week	City	State	Zip Code

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

C. RETURN TO WORK STATUS

- ☐ Closed After Evaluation/Working
- ☐ Same Employer, Same or Modified Job
- ☐ Same Employer, Different Job
- ☐ Same Employer, OJT
- ☐ New Employer, Different Job
- ☐ New Employer, OJT
- ☐ New Employer, After Training
- ☐ Self-Employment
- ☐ RTW After Settlement
- ☐ Other (Specify):

D. NOT RETURNED TO WORK

- ☐ Rehabilitation Not Needed
- ☐ Rehabilitation Not Feasible
- ☐ Medical Goal Attained
- ☐ Settled, Rehabilitation Closed
- ☐ Settled, Rehabilitation Expired
- ☐ Change of Supplier
- ☐ Closed for Training
- ☐ Board Decision (Attach Copy)
- ☐ Other (Specify):

E. REHABILITATION COST

(This section must be completed by rehabilitation supplier)

1. Number of Weeks	2. Medical Care Coordination	3. Vocational Services	4. Total Rehabilitation Costs

F. CERTIFICATE OF SERVICE

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Print or Type Name	Signature

G. APPROVAL / OBJECTIONS, TWENTY (20) DAY NOTICE

The Board will issue an Administrative Decision whether or not an objection is received.

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the Georgia State Board of Workers' compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST FOR COPY OF BOARD RECORDS

A minimum charge of $10.00 will be incurred for 10 copies or less, with a charge of $0.50 for each additional copy.
To cancel a request please call 404-656-2924

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. TYPE OF COPIES

Date of Birth:

☐ Cerifitied Copy (Additional $10 charge for each certified copy)

☐ Current Case ☐ Priors ☐ Subsequent

☐ Other

B. REQUEST FOR CERTIFIED EMPLOYER INSURANCE COVERAGE INFORMATION

(All Insurance coverage information is certified with an additional $10.00 charge for certification)

Employer Name	Doing Business As:		
Address	City	State	Zip Code

C. CERTIFICATION

☐ I hereby certify that I have this day sent a copy of this form to all of the parties to this claim, and have filed this form to the State Board of Workers' Compensation, 270 Peachtree Street, NW, Atlanta, GA 30303-1299, this _____ (Day) day of _____ (Month) / _____ (Year)

Name	Law Firm or Company	
Signature	Party for	
Phone and Ext.	E-mail	GA Bar Number

ADDRESS LABEL

In this space type the address to which you want these copies mailed.

FOR BOARD USE ONLY

Do not write in this space

Invoice Date	Invoice Number
Number of Pages	Copied By:

Additional Board Claim Numbers	Additional Dates of Injury

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYEE'S REQUEST FOR CATASTROPHIC DESIGNATION

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Birthdate	Occupation		
Mailing Address			Treating Physician		
City	State	Zip Code	Physician's Specialty		
Phone Number	E-mail		Diagnosis – Secondary Condition		
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name	
Mailing Address			**CLAIMS OFFICE**	Name	
			Mailing Address		
City	State	Zip Code	City	State	Zip Code
			SBWC ID# (five-digit no.)	Insurer/Self-Insurer File #	
Phone Number	E-mail		Phone Number	E-mail	
ATTORNEY FOR EMPLOYEE/ CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/ INSURER**	Name	
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Phone Number	E-mail		Phone Number	E-mail	
OTHER PARTY	Name		**PROPOSED SUPPLIER**	Name	Reg. No.
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Phone Number	E-mail Address		Phone Number	Mailing Address	

B. REQUEST FOR A SPECIFIC CATASTROPHIC REHABILITATION SUPPLIER

The Board will issue an Administrative Decision on this request, whether or not an objection is received. The rehabilitation supplier requested on this document shall not initiate provision of rehabilitation services for this employee until and unless the Board issues an Administrative Decision naming that supplier to work with this employee.

Name of requested Catastrophic Rehabilitation Supplier	Registration No.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT https://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

C. THIS SECTION MUST BE COMPLETED FOR ALL REQUESTS

Employee's Education Level :

Employee's Work History for the last 15 years prior to injury, including physical requirements of each job (e.g. pounds lifted, hours standing / sitting / walking, etc.)

Dates/Job Title	Physical Requirements

Attach this form to a statement from this employee's authorized treating physician(s) indicating the physician(s)' opinion of the employee's work ability. This statement must be dated no more than one year prior to the certified mailing date of this form. This must be submitted even if the employee is receiving social security disability (SSDI) or supplemental security income (SSI) benefits.

D. CERTIFICATE OF SERVICE

This section must be completed by the requesting party.

☐ I certify that I have sent copies to the following parties on _____ (Month) / _____ (Day) / _____ (Year) at the current addresses above.

Signature	Mailing Address		
Company / Firm Name			
E-mail Address	City	State	Zip Code

E. OBJECTION, TWENTY (20) DAY NOTICE

The Board will issue an Administrative Decision, whether or not an objection is received.

If there is an objection:

(1) The objection must be filed on the WC-Rehab Objection Form with attached arguments and sent to all parties and to any/all involved rehabilitation suppliers.
(2) The objection must be received by the State Board of Workers' Compensation within 20 days of the date of the certificate of service.
(3) A certificate of service must be completed stating that copies of the WC-Rehab Objection Form were sent to all parties and any/all involved rehabilitation suppliers the same date as the certificate of service.

WC-14 NOTICE OF CLAIM

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check only one: ☐ NOTICE OF CLAIM ONLY ☐ REQUEST FOR HEARING / NOTICE OF CLAIM ☐ REQUEST FOR MEDIATION / NOTICE OF CLAIM

Complete a new Form WC-14 to add an additional employer, insurer or to add date of injury.
If you need additional space, do not alter this form, but instead attach additional sheets. Must be typed or printed in black ink.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	County of Injury	Mailing Address		
Employee E-mail	Phone Number		City	State	Zip Code

EMPLOYER	Name		INSURER/ SELF- INSURER	Name	SBWC# (five digit #)
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code
Employer E-mail	Phone Number		Insurer E-mail	Phone Number	

ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		ATTORNEY FOR EMPLOYER/INSURER	Name	
Mailing Address	GA Bar Number		Mailing Address	GA Bar Number	
City	State	Zip Code	City	State	Zip Code
Attorney E-mail	Phone Number		Attorney E-mail	Phone Number	

1. Part of Body Injured	2. First Date Disabled	3. If Fatal – Enter complete date of death Claimants for death benefits (list names & addresses) attach additional sheets

4. Description of Accident

B. HEARING / MEDIATION ISSUES

☐ Income Benefits ☐TTD(Dates) ☐TPD(Dates) ☐PPD(Dates)

☐ Medical Benefits List Benefits:

☐ Suspension / Termination Request Effective Date

Reason:

☐ Dependency Benefits ☐ Burial Expenses

☐ Penalties / Assessed Attorney Fees
☐§34-9-221e ☐§34-9-108b (1) ☐§34-9-108b(2) ☐Other

☐ Request for Catastrophic Designation Specify:

☐ Appeal of Rehabilitation Decision Specify:

☐ Other Hearing Issues Specify:

Additional Board Claim Numbers which will be involved (if any):
☐ _____
(Complete a separate form WC14 for each date of accident)

C. AFFIRMATION OF FILING PARTY

☐ I, [the person whose name appears above], attest and affirm that all information contained herein is true and correct to the best of my knowledge. I understand that knowingly giving false information to obtain or deny workers' compensation benefits subjects me to civil and criminal penalties.

D. ENTRY OF APPEARANCE

☐ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102. (fee contract or WC-102B has been previously filed or is attached)

E. CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date

Phone Number	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. § 34-9-18 AND § 34-9-19).

For injuries occurring on or after July 1, 2007, any claim filed with the Board for which neither medical nor income benefits have been paid shall stand dismissed with prejudice by operation of law if no hearing has been held within five years of the alleged date of injury. (O.C.G.A. § 34-9-100)

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

REQUEST TO CHANGE INFORMATION ON A PREVIOUSLY FILED FORM WC-14

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	County of Injury	Mailing Address		
Employee E-mail	Phone Number		City	State	Zip Code
EMPLOYER	Name		**INSURER/ SELF-INSURER**	Name	
Mailing Address			**CLAIMS OFFICE**	Name	
			SBWC ID #	Mailing Address	
City	State	Zip Code	City	State	Zip Code
Employer E-mail	Phone Number		Claims E-mail	Phone Number	
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/INSURER**	Name	
Mailing Address	GA Bar Number		Mailing Address	GA Bar Number	
City	State	Zip Code	City	State	Zip Code
Attorney E-mail	Phone Number		Attorney E-mail	Phone Number	

B. INFORMATION TO BE AMENDED

The information provided on the Form WC-14 dated _____ is amended as follows:

☐ Date of Injury (Can only be amended +/- 30 days from previous date of injury.)	Change Date of Injury From:	Change Date of Injury To:
☐ Correct an Employer's Name Only	Existing Employer Name:	Corrected Employer Name:
☐ Dismiss a Party ☐ Employer ☐ Insurer ☐ Claims Office	Party Name / City	Address / State / Zip Code
☐ Add Additional Hearing Issues Only (Max 50 Characters)	(DO NOT USE THIS SECTION TO ADD/DELETE PARTIES.)	

C. AFFIRMATION OF FILING PARTY

☐ I, (the person whose name appears above), attest and affirm that all information contained herein is true and correct to the best of my knowledge. I understand that knowingly giving false information to obtain or deny workers' compensation benefits subjects me to civil and criminal penalties.

D. ENTRY OF APPEARANCE

☐ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102 (fee contract or WC-102B has been previously filed or is attached).

E. CERTIFICATE OF SERVICE

☐ I certify that I have today sent a copy of this form to all parties named above, and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date

Phone Number	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

EMPLOYEE HANDBOOK

Please be aware that the Workers' Compensation Law, Rules and Regulations are subject to change on July 1st of each year. If you have any questions about the information contained in this handbook, please contact your employer, adjuster, or the State Board of Workers' Compensation.

July 2019

Our Pledge to Employees

If you are injured on the job, you have certain rights, benefits and responsibilities. Your employer also has obligations and responsibilities regarding all employees. The main focus of _____ is to assist job-related injured workers in receiving immediate and quality medical care, to administer workers' compensation claims from the initial injury until the closing of the claim, and to safely return lost-time employees to productive employment. We believe that a healthy, safety conscious and productive company is the result of healthy, safety conscious and cooperative employees.

The staff of _____ understands an employee's and a family's concern when a wage earner is injured on the job and cannot work. We are here to help you through this difficult time.

- We pledge to give each injured employee individual attention.
- We pledge to handle your claim in a prompt and courteous manner.
- We pledge to fully inform you of all workers' compensation income benefits you are entitled to receive and to pay these benefits to you in a timely manner.
- We pledge to pay all authorized medical expenses in a prompt and accurate manner.
- We pledge to make every effort to work with you in returning you to your regular job should your injury require you to lose time from work.

_____
Company Name

State Board of Workers' Compensation
Bill of Rights for the Injured Worker

As required by law, O.C.G.A. (34-9-81.1), this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

EMPLOYEE'S RIGHTS

1. If you are injured on the job, you may receive medical, rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO which provides medical care. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over; then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage up to the maximum allowed under the law for a job-related injury for as long as you are unable to return to work. You are also entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area, call the State Board of Workers' Compensation at (404) 656-3818 or toll-free number (800) 533-0682. Your employer will advise you of the amount of your weekly benefit.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage, but not more than the maximum allowed under the law for a job-related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage, but no more than the maximum allowed under the law, not to exceed 350 weeks.
7. When you are able to return to work but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than the maximum allowed under the law for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to the maximum allowed under the law and two-thirds of your average weekly wage, but not more than the maximum allowed under the law. A widowed spouse with no children will be paid a maximum allowed by law at the time of injury. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.

9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty which will be added to your payments.

EMPLOYEE'S RESPONSIBLITIES

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are entitled to income benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000 or imprisonment up to 12 months, or both for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area, the telephone number is (404) 656-3818. Outside the metro Atlanta area, call 1-800-533-0682 or write the State Board of Workers' Compensation at: 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777.

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000 per violation (O.C.G.A. 34-9-18 and 34-9-19).

Workers' Compensation Questions and Answers

GENERAL QUESTIONS

Q. What is Workers' Compensation?

Workers' compensation is a benefits program created by state law that provides medical, rehabilitation, income, death and other benefits to employees and dependents due to injury, illness and death resulting from a compensable work-related claim covered by the law.

Q. When am I covered?

Workers' compensation coverage begins the first day of employment. Employers with three or more employees are required by law to provide coverage.

Q. What is considered an on-the-job injury, illness and death claim?

Any injury, illness or death arising out of and in the course of employment is by definition a compensable work-related claim. This means if employees are injured while performing assigned job duties during assigned work hours, they are covered under the workers' compensation program. Injuries sustained while engaging in unassigned duties, during lunch and breaks, are not covered. In addition, injuries that occur during an employee's normal commute to and from work are not covered.

Q. If I am injured on the job, what should I do?

You should **IMMEDIATELY** report your injury to your employer. Obtain and fill out the paperwork required by your company and forward to the appropriate organization for processing. Be as specific as possible when reporting your injury. If anyone witnessed your accident, inform your employer of such a witness. Prompt notification will enable your company to begin your benefits in a timely manner.

Q. What happens if I cannot make a report of my injury?

If your injury is such that you are unable to make a report, you will be provided immediate medical assistance and a report will be made for you. Others reporting the injury should also be as specific as possible when reporting the accident, and the report should be turned over to the employer as soon as possible.

Q. Are on-the-job accidents or injuries investigated?

Yes. Your employer and/or the company responsible for handling workers' compensation claims generally investigate on-the-job accidents and injuries. Investigations are necessary to determine why and how the injury occurred, and to implement policies and procedures to make the workplace safer.

Q. Are employee misconduct claims resulting from on-the-job injuries covered?

No. Workers' compensation does not provide benefits for an injury or accident resulting from an employee's willful misconduct (i.e. fighting, horseplay, willful act of third party for personal reasons, injuries related to alcohol or drug abuse).

Q. Are injuries resulting from haste and inattentiveness covered?

Yes. These types of injuries would be covered under the workers' compensation program. However, employees are encouraged to follow company policies and safety rules and may subject themselves to company discipline if these rules are not adhered to.

Q. What if I am concerned about my safety record?

Many companies have established safety programs to encourage employees to be safety conscious when performing their job duties. These programs usually offer certain awards to employees. Employees do not like to be responsible for causing their work group to miss safety goals. However, failure to report injuries because of safety programs could result in long-term consequences for the employee, as well as out-of-pocket medical expenses.

Q. Can I receive from my employer money damages in addition to workers' compensation benefits if I am injured on the job?

No. Workers' compensation is the "exclusive remedy" a worker has against his/her employer for damages resulting from an on-the-job injury.

Q. Can I sue anyone for a work-related injury?

If your injury was caused by the negligence of a third party other than another person who is also an employee of the company for which you work, you may have a right to sue that party. If you sue and receive a dollar award, your employer may have a right to recover some or all of the cost expended in your workers' compensation claim. This is known as a subrogation lien. The lien would only be recoverable after you had been fully compensated for your loss resulting from your on-the-job injury.

Q. How much will an attorney charge to handle a workers' compensation claim?

Most workers' compensation claims can be handled without having to hire an attorney. However, if you feel that an attorney is needed, the Workers' Compensation Statute limits the attorney's fee to a maximum of 25% of income benefits received, not to exceed 400 weeks of benefits. In addition, you would also be responsible for paying any expenses associated with the pursuit of your claim.

Q. How can I jeopardize my benefits?

- Failure to report injuries promptly.
- Failure to cooperate with employer and authorized treating physician regarding medical evaluations, treatment, rehabilitation services and claim investigation.
- Refusal to return to suitable employment.
- Working elsewhere while receiving Temporary Total Disability Benefits.

- Submittal of fraudulent information.
- Refusal to take a drug test.
- Refusal to submit to a medical examination by the authorized treating physician, at reasonable times.

Q. Are there circumstances where I would not receive workers' compensation benefits as a result of an on-the-job injury?

Yes. For instance, benefits are not payable if you are injured while engaged in willful misconduct or if your injury is due to the use of alcohol or drugs or the misuse of controlled substances.

Q. Does the State Board of Workers' Compensation investigate fraud?

Yes. The Board has an Enforcement Division that investigates allegations of fraud. The Board also has authority to assess civil penalties of up to $10,000 for violations involving fraud.

MEDICAL BENEFIT QUESTIONS

Q. May I go to my personal physician for treatment for my on-the-job injury?

No. The law requires that you select from a list of physicians posted by your company in a prominent location. In addition, the law requires that you are informed of this list and understand its function. One of the following referral methods may be used.

Panel of Physicians – This must contain at least six qualified physicians. The makeup of the panel must include one orthopedic surgeon, a minority physician and four other properly qualified physicians.

Workers' Compensation Managed Care Organization (WC/MCO) – A WC/MCO offers a much larger choice of treating physicians from many disciplines. The WC/MCO must be approved by the State Board of Workers' Compensation.

If you are dissatisfied with your first selection, you may make one change to another physician from the posted list. Any further change of physician will require concurrence of your company and/or the workers' compensation administrator.

Should you choose to go to a doctor not on the approved list, this is considered unauthorized treatment, and your employer will not be responsible for the cost associated with this medical care. In addition, most health insurance policies will not pay for medical treatment associated with an on-the-job injury.

Q. How will I identify the List of Physicians?

The list of physicians will be printed on 8.5´x 14" paper titled "OFFICIAL NOTICE. This business operates under the Georgia Workers' Compensation Law." It will contain the name, specialty, address and phone number of the authorized physicians.

Q. What must I do if I need emergency treatment?

In a true emergency situation, you may get temporary medical care from the nearest emergency location available. Once the emergency is over, however, you must continue your care by selecting a doctor from the list of physicians provided by your employer.

Q. What happens if I need surgery?

Prior to scheduling any major surgical procedures for an on-the-job injury, except in the case of an emergency, your doctor will notify your employer or workers' compensation provider. Once your employer has been contacted, the appropriate workers' compensation professional will work with your physician and/or his/her medical staff to ensure that all the necessary arrangements are made.

Q. What if the doctor says that I need a MRI or CT scan?

Your authorized treating physician will arrange for these tests. Feel free to ask your physician what the test is for and why you need it.

Q. What if I need physical therapy?

Your authorized treating physician will refer you to a physical therapy provider.

Q. Am I required to pay a portion of the cost of the medical care I receive resulting from my on-the-job injury?

No. Your physician's bills and reasonable medical bills are covered if a physician authorized by your employer treats you. All medical charges are paid according to the Georgia Workers' Compensation Medical Fee Schedule. If your medical provider charges above the fee schedule, the charges will be reduced to the fee schedule, and that amount will be paid. **YOU ARE NOT RESPONSIBLE FOR CHARGES ABOVE THE FEE SCHEDULE;** however, if you are billed for those costs, contact your employer or workers' compensation provider to assist in getting the charges corrected.

Q. If the physician prescribes medicines for me, what do I do?

Prescription drugs are covered under workers' compensation. Check with your employer or workers' compensation administrator to see if they have any special procedures in place for obtaining prescription drugs. If no special arrangements have been made, you may have to pay for the prescription and submit the bill to your employer for reimbursement.

Q. Are there any expenses that I incur that will be reimbursed to me?

The Workers' Compensation Statute provides for reimbursement of certain reasonable personal expenses incurred to obtain medical treatment. This includes such things as mileage, meals, lodging and other expenses, in limited instances, which are deemed necessary and appropriate in order to ensure you receive quality medical care. You should check with your workers' compensation professionals before incurring expenses.

Q. How long do reimbursements take?

Approved expenses will be reimbursed within 15 days of submission as required by the Workers' Compensation Statute. However, most carriers process reimbursements in less time. If reimbursements are not paid within fifteen (15) days of receipt of documentation requesting reimbursement, penalties shall be added in addition to the reimbursement amount. It is important to submit your approved expenses within a year's time of the date of service otherwise you will have waived your right to collect such charges from the employer or workers' compensation insurer.

DISABILITY BENEFIT QUESTIONS

Q. What will happen if I am unable to work because of my on-the-job injury?

You are entitled to receive weekly **Temporary Total Disability** benefits if you miss **more than** seven days from work. Only if you are out more than 21 consecutive days due to your injury will you be paid for the first seven days. Your first check should be mailed to you within 21 days after the first day of disability. You will receive two-thirds of your average weekly wage, but not more than the maximum rate provided by the Workers' Compensation act at the time of your injury. Your authorized treating physician must verify your disability and absence from work.

Q. What if I cannot perform my regular job and another job is not available?

You would be eligible to receive Temporary Total Disability benefits if you are unable to work due to your on-the-job injury. You should also consult your employer regarding possible vocational rehabilitation opportunities.

Q. What happens if my disability becomes permanent?

If your authorized treating physician determines you have suffered a permanent disability, you would be entitled to receive Temporary Total Disability benefits for as long as you remain disabled. If you are able to work, you would begin receiving a weekly income benefit based on the permanent disability rating given you by your authorized treating physician. (See next question – **PERMANENT PARTIAL DISABILITY).** The benefit would be paid to you regardless of your wage rate or total income.

Q. What income benefits are available under the Workers' Compensation Program?

The Workers' Compensation Statue provides four basic income benefits. The maximum amount of weekly workers' compensation benefits an employee can receive from an on-the-job injury, illness or death depends on the workers' compensation rate at the time of the injury and the employee's average weekly wage.

Temporary Total Disability Benefits – This benefit is payable to an employee who is injured on the job and unable to work as determined by the authorized treating physician. The amount is two-thirds of the employee's average weekly wage at the time of the injury, not to exceed the maximum amount allowed under the law. For non-catastrophic injuries, there is a limit of 400 weeks of benefits from date of injury if the injury occurred on or after July 1, 1992. For catastrophic injuries, benefits are unlimited.

Temporary Partial Disability Benefits – This benefit is payable to an employee when he/she returns to work in a job paying less as a result of an on-the-job accident. These benefits are payable for up to 350 weeks from the date of injury. This lost wage amount is two-thirds of the difference between the employee's average weekly wage before and after the injury. The maximum amount payable cannot exceed the maximum allowed under the law.

Permanent Partial Disability Benefits – This benefit is payable to the employee for a permanent disability resulting from an on-the-job injury. It is payable based upon a percentage given by your authorized treating physician in accordance with current AMA Guidelines. The percentage is calculated by a formula that contains number of weeks assigned by O.C.G.A 34-9-263(c) multiplied by the percentage rating multiplied by the Temporary Total Disability rate. Not all injuries result in ratings assigned by a physician.

Death Benefits – This benefit is payable to eligible dependents (i.e., dependent spouse, minor children) of an employee whose on-the-job injuries result in death. This benefit is payable at the rate of two-thirds of the deceased employee's average weekly wage at the time of the accident not to exceed the maximum

allowed under the law for all eligible dependents. **Funeral Expenses** are payable up to the maximum allowed under the law at the time of injury.

Benefits cannot be combined. Only one type of benefit is payable at a time.

Q. What happens to my workers' compensation benefits if I receive a light-duty release from my physician while I am out of work?

Your employer will try to place you in a job that meets the limitations placed on you by your physician. However, if a light-duty job is not available and you remain out of work in a light-duty status for 52 consecutive weeks or, if periods of disability are interrupted, a maximum of 78 total calendar weeks, your income benefits will be reduced automatically by law from the Temporary Total Disability benefit to the maximum eligible Temporary Partial Disability benefit.

If you are given a light-duty release and a light-duty job is available, your employer will expect you to return to work. The Workers' Compensation Statue provides for a 15-working-day "grace period." This allows an employee to attempt to perform a light-duty job without fear of losing benefits if they are unable to perform the job duties. An attempt is defined by eight cumulative hours or one scheduled workday, whichever is greater.

QUESTIONS ABOUT SPECIFIC INJURIES

Q. Can I be compensated for occupational related diseases?

Yes. If your disease meets certain tests imposed by law, you can be compensated. There must be a causal relationship between your employment and the disease. It cannot be a disease that is an ordinary disease of life to which others are exposed.

Q. What happens if I re-injure a pre-existing condition or injury?

The Workers' Compensation Act limits the extent to which an aggravation of a pre-existing condition or injury is compensable. An aggravation of an on-the-job injury is compensable while the aggravation is the cause of the disability. Once the aggravation resolves and you return to the pre-injury condition, the claim will no longer be compensable.

Q. Can I be compensated for a repetitive motion injury?

Yes. Repetitive motion injuries are compensable if they arise out of and in the course of employment.

Q. What is a catastrophic injury?

Catastrophic injuries are extremely severe injuries, i.e., loss of limbs, severe burns, etc. Your employer is required to appoint a rehabilitation supplier who has expertise in handling catastrophic cases. This person would assist you in managing your medical care as well as any other assistance you might need in the recovery period following the accident. You will be entitled to Temporary Total Disability benefits for as long as you remain unable to work. Once you have returned to work, the Temporary Total Disability benefits will cease. If you are placed in a lower paying job, you will begin receiving Temporary Partial Disability benefits. After those benefits have been paid, you will begin receiving Permanent Partial Disability benefits.

Q. Are heart attacks and strokes covered under workers' compensation?

Heart attacks and strokes are not considered injuries under workers' compensation unless it is shown by a preponderance of competent and credible evidence, which shall include medical evidence, that the condition was attributable to the performance of the usual work of employment.

QUESTIONS REGARDING TIME LIMITS/FILING CLAIMS

Q. What if my employer or workers' compensation administrator denies my claim?

If your claim is denied, you will be notified of the reason for the denial. You have the right to request a hearing from the State Board of Workers' Compensation if you disagree with the denial of your claim. A claim with the State Board must be filed within one year of the date of injury. The procedure for filing a claim with the State Board of Workers' Compensation is outlined on the back of the Workers' Compensation form titled "Employer's First Report of Injury" (WC-1).

Q. Is there a time limit or statute of limitation on filing a workers' compensation claim and if so, what is it?

After properly reporting an injury, you have one year from the date of the injury to file a claim. If you received remedial treatment from your employer for the injury, you have one year from the date of treatment to file a claim for workers' compensation benefits. If you received weekly income benefits as a result of the on-the-job injury, you have two years from the date of your last payment of weekly income benefits to file a claim.

In the case of an occupational disease claim, you have one year from the date you become aware of your disease or, in the exercise of reasonable diligence, should have known of the relationship between your disability and its relationship to your employment. No claim for an occupational disease may be filed after seven years from the last date you were exposed to the employment hazards related to your disease. However, for the diseases asbestosis or mesothelioma related to exposure to asbestos, you have one year from the date of first disablement after diagnosis to file a claim.

Q. Once I'm treated for my injury and have reached maximum medical improvement and begin having problems in the future due to my injury, may I receive additional treatment for this injury?

All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum period of 400 weeks from the accident date. If your injury is catastrophic in nature, you may be entitled to lifetime medical benefits.

Q. When could my claim be closed?

When appropriate benefits have been paid, or once a settlement agreement is reached by all parties and approved by the State Board of Workers' Compensation and a monetary amount is paid to you or your dependents, your claim is closed. Note that not all claims are closed. Some claims, due to the nature of the injury, remain open until the statute of limitations runs, or until the injured worker's death, whichever occurs first.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

BILL OF RIGHTS FOR THE INJURED WORKER

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Workers' Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Workers' Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

Employee's Rights

1. **If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.**

2. **Your employer is required to post a list of at least six doctors or the name of the certified WC/MCO that provides medical care, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.**

3. **Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.**

4. **You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.**

5. **Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-0849.**

6. **In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than $800 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks. If you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than $533.33 per week, not to exceed 350 weeks.**

7. **When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than $533.33 per week for no longer than 350 weeks.**

8. **Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to $7,500 and two-thirds of your average weekly wage, but not more than $800 per week. A widowed spouse with no children will be paid a maximum of $320,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.**

9. **If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.**

Employee's Responsibilities

1. **You should follow written rules of safety and other reasonable policies and procedures of the employer.**

2. **You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.**

3. **An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.**

4. **No compensation shall be allowed for an injury or death due to the employee's willful misconduct.**

5. **You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.**

6. **A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.**

7. **You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.**

8. **If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.**

9. **If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.**

10. **Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.**

11. **If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.**

12. **You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than $10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.**

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299 or visit our website: https://www.sbwc.georgia.gov. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-334-6865.

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. **Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.**

2. **Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.**

3. **Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.**

4. **Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que falto al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.**

5. **Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de $800 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.**

6. **En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de $800 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de $533.33 por semana, que no excedan 350 semanas.**

7. **Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de $533.33 por semana pero no más de 350 semanas.**

8. **En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro $7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de $800 por semana. Una esposa viuda sin niños se le pagara un máximo de $320,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.**

9. **Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.**

Responsabilidades de los Empleados

1. **Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.**

2. **Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la perdida de sus beneficios.**

3. **Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.**

4. **No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.**

5. **Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.**

6. **Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.**

7. **Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.**

8. **Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.**

9. **Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.**

10. **Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.**

11. **Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.**

12. **Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de $10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.**

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: https://www.sbwc.georgia.gov. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-334-6865.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

PETITION FOR APPOINTMENT OF TEMPORARY CONSERVATOR OF MINOR(S)

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

EMPLOYEE IDENTIFYING INFORMATION

Mailing Address			County of Injury	Phone Number
City	**State**	**Zip Code**	**Employee E-mail**	

PETITIONER IDENTIFYING INFORMATION

Last Name		First Name	M.I.	Petitioner Social Security Number
Mailing Address			**Date of Birth**	**County of Residence**
City	**State**	**Zip Code**	**Petitioner E-mail**	**Phone Number**

Re: _____ , Minor(s)

1. Pursuant to the provisions of O.C.G.A. §34-9-226 _____
(name of petitioner)
hereby petitions the State Board of Workers' Compensation to appoint a temporary conservator for the above-referenced minor(s) to bring or defend an action under this chapter, to receive and administer weekly income benefits on behalf of and for the benefit of said minor(s) and/or to compromise and terminate any claim and receive any sum in settlement for the benefit of and use of said minor(s) where the net settlement amount is less than $100,000.

2. The minor(s) date(s) of birth is (are) _____

3. Petitioner is the _____
(state the relationship between petitioner and minor(s) and attach supporting documentation such as marriage or birth certificates, orders of custody or support, etc.)

4. The minor child or children reside with the petitioner: ☐ Yes ☐ No

5. The Board should exercise its discretion and allow petitioner as natural conservator to receive and administer workers' compensation benefits for said minor(s).

6. Petitioner will hold and use such property for the benefit of the minor(s) and shall be legally accountable to the minor(s) for the proper handling of such property.

ATTORNEY (If applicable)	Name		Phone Number
Mailing Address			GA Bar Number
City	State	Zip Code	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

VERIFICATION

Personally appeared before me the undersigned petitioner who on this oath states that the facts set forth in the foregoing petition are true.

Petitioner Name	Mailing Address		
Phone Number	City	State	Zip Code

Petitioner Signature

Sworn to and subscribed before me this _____ (day) day of _____ (month), _____ (year).

_____
Notary Public

CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, GA 30303-1299.

Signature	Date

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CONFIDENTIAL

EMPLOYEE / CLAIMANT	Name	Claim Number

_____ , Minor(s), Petition for Appointment of Temporary Conservator of Minor(s).

CONSENT FORM

I hereby authorize the State Board of Workers' Compensation to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I have attached a copy of a criminal history record check for each jurisdiction, other than Georgia, where I have resided at any time during the five year period immediately prior to the date of this petition.

I have lived in the following states other than Georgia:

State	Period

I have never been arrested or convicted of any crime in Georgia or any other state except as follows:

Date	Crime	Disposition	State

Full Name		Signature of Petitioner		
Birthdate	Social Security Number	Mailing Address		
Sex	Race	City	State	Zip Code

Sworn to and subscribed before me this _____ (day) day of _____ (month) , _____ (year) .

_____
Notary Public

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

PETITION FOR APPOINTMENT OF TEMPORARY CONSERVATOR FOR LEGALLY INCAPACITATED ADULT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

EMPLOYEE IDENTIFYING INFORMATION

Mailing Address			County of Injury	
City	State	Zip Code	Employee E-mail	Phone Number

PETITIONER IDENTIFYING INFORMATION

Last Name	First Name	M.I.	Petitioner Social Security Number

Mailing Address			Birthdate	County of Residence
City	State	Zip Code	Petitioner E-mail	Phone Number

Re: _____ , name of Legally Incapacitated Adult,
Petition for Appointment of Temporary Conservator of Legally Incapacitated Adult.

1. Pursuant to the provisions of O.C.G.A. §34-9-226 _____
(name of petitioner)
hereby petitions the State Board of Workers' Compensation to appoint a temporary conservator for the above-referenced legally incapacitated adult to bring or defend an action under this Chapter, to receive and administer weekly income benefits on behalf of and for the benefit of said legally incapacitated adult and/or to compromise and terminate any claim and receive any sum in settlement for the benefit of and use of said legally incapacitated adult where the net settlement amount is less than $100,000.

2. _____
(State the relationship between the petitioner and the incapacitated adult and attach supporting documentation including marriage certificates, birth certificates, or orders of custody or support, etc.)

3. _____
(State the reasons the conservator is necessary including facts which support the claim of incapacity. This petition must be accompanied by an affidavit given by a qualified physician who has recently examined the alleged legally incapacitated adult.)

4. (List the names and addresses of the spouse and all adult children of the incapacitated adult who are living and whose addresses are known; or if none, then the names and addresses of the two next of kin who are living and whose addresses are known; or if only one next of kin, then that one; or if none, then the names and addresses of two adult friends.

Name			Name		
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code

5. (List the names and addresses of any appointed representatives of the incapacitated adult.)

Name			Name		
Mailing Address			Mailing Address		
City	State	Zip Code	City	State	Zip Code

6. The Board should exercise its discretion and allow petitioner to receive and administer workers' compensation benefits for said legally incapacitated adult.

7. Petitioner will hold and use such property for the benefit of the legally incapacitated adult and shall be legally accountable to the legally incapacitated adult for the proper handling of such property.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

ATTORNEY (If applicable)	Name		Phone Number
Mailing Address			GA Bar Number
City	State	Zip Code	E-mail

VERIFICATION

Personally appeared before me the undersigned petitioner who on this oath states that the facts set forth in the foregoing petition are true.

Petitioner Name	Mailing Address		
Phone Number	City	State	Zip Code

Sworn to and subscribed before me this _____ (day) day of _____ (month), _____ (year).

_____
Notary Public

CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all parties named above and to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, GA 30303-1299.

Signature	Date

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CONFIDENTIAL

EMPLOYEE / CLAIMANT	Name	Claim Number

_____ , name of Legally Incapacitated Adult, Petition for appointment of Temporary Conservator for Legally Incapacitated Adult.

CONSENT FORM

I hereby authorize the State Board of Workers' Compensation to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I have attached a copy of a criminal history record check for each jurisdiction, other than Georgia, where I have resided at any time during the five year period immediately prior to the date of this petition.

I have lived in the following states other than Georgia:

State	Period

I have never been arrested or convicted of any crime in Georgia or any other state except as follows:

Date	Crime	Disposition	State

Full Name		Signature of Petitioner		
Birthdate	Social Security Number	Mailing Address		
Sex	Race	City	State	Zip Code

Sworn to and subscribed before me this _____ (day) day of _____ (month) , _____ (year) .

_____
Notary Public

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

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