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.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

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

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. **A copy of the Form WC-104 is attached**.

❑ 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 and ext.	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. OUTLINE OF BENEFITS OTHER THAN MEDICAL EXPENSE

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

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 $450 per week if your date of accident was on or after July 1, 2005, and a maximum of $500 per week if your date of accident was on or after July 1, 2007.

- 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

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 $300 per week if your date of accident was on or after July 1, 2005, and a maximum of $334 per week if your date of accident was on or after July 1, 2007 for a maximum of 350 weeks from the date of accident.

PERMANENT PARTIAL

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.

B. 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
In Atlanta: 404-656-3818
or: 1-800-533-0682
http://www.sbwc.georgia.gov

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