GEORGIA STATE BOARD OF WORKERS' COMPENSATION
NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

_____ Commence MCO ❑ Yes No ❑

_____ Suspend _____ Insurer File Number

_____ Amend the WC-1/WC-2 dated _____ ( ) _____ _____

as indicated in ____ Part A Below/____ Part B Below Employee's Phone No. Social Security Number

_____ _____

Employee Name (First) (Middle) (Last) Date of Injury

_____ _____

Employee Street Address City State Zip Date of Disability

_____ _____

Employer Insurer

_____ _____

Address Address

_____ _____

City State Zip Phone City State Zip Phone

____ A. Benefits are being paid to this employee at the rate of $_____* per week based on an average weekly wage of $_____, payable from ____/____/____ for:

____ total/temporary total disability

____ temporary partial disability

____ permanent partial disability of _____% to _____ to be paid for _____ weeks
(part of body)

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.

____ B. 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 A 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.)

____ 5) The employee has had a change in condition pursuant to O.C.G.A. §34-9-104(a)(2) because he or she 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 (60) days of the release. Temporary partial disability benefits are shown in Part A above.

____ 6) This was not a catastrophic injury, and the maximum number of temporary total disability payments has been paid.

____ 7) The entire permanent partial disability benefit has been paid.

____ 8) The maximum number of temporary partial disability payments has been paid.

____ 9) This claim is being controverted within sixty (60) days of the due date of first payment, and a Notice to Controvert, Form WC-3, is being filed with the Board, with a copy sent to the employee.

____ 10) Other: _____

By _____ ( ) _____

(Type or Print and Sign) (Date) (Phone)

The original of this form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be given to the person receiving benefits when payments are started and when payments are stopped.

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).

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.

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 $400 per week if your date of accident was on or after July 1, 2001, and a maximum of $425 per week if your date of accident was on or after July 1, 2003.

- A minimum of $42.50 per week, or your actual weekly wage if less than $42.50 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.

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 $268 per week if your date of accident was on or after July 1, 2001, and a maximum of $284 per week if your date of accident was on or after July 1, 2003, for a maximum of 350 weeks from the date of accident.

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 those 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 an income benefit. 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, write to the address below and ask for one to be mailed to you, or call 1-800-533-0682 (in Atlanta, 404-656-3870) for claim assistance.

STATE BOARD OF WORKERS' COMPENSATION
270 PEACHTREE STREET, N.W.,
ATLANTA, GEORGIA 30303-1299
http://www.ganet.org/sbwc/

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