

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check only one: NOTICE OF CLAIM ONLY REQUEST 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				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				Insurer E-mail			
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				Attorney E-mail			
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							
<input type="checkbox"/> Income Benefits	<input type="checkbox"/> TTD(Dates) _____	<input type="checkbox"/> TPD(Dates) _____	<input type="checkbox"/> PPD(Dates) _____	<input type="checkbox"/> Medical Benefits	List Benefits: _____		
<input type="checkbox"/> Dependency Benefits	<input type="checkbox"/> Burial Expenses	<input type="checkbox"/> Suspension / Termination Request	Effective Date _____				
<input type="checkbox"/> Penalties / Assessed Attorney Fees	<input type="checkbox"/> §34-9-221e	<input type="checkbox"/> §34-9-108b (1)	<input type="checkbox"/> §34-9-108b(2)	<input type="checkbox"/> Other	Reason: _____		
<input type="checkbox"/> Request for Catastrophic Designation	Specify: _____			<input type="checkbox"/> Appeal of Rehabilitation Decision	Specify: _____		
<input type="checkbox"/> Other Hearing Issues	Specify: _____			Additional Board Claim Numbers which will be involved (if any): <input type="checkbox"/> _____ (Complete a separate form WC14 for each date of accident)			
C. AFFIRMATION OF FILING PARTY							
<input type="checkbox"/> 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							
<input type="checkbox"/> 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							
<input type="checkbox"/> 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.sbwg.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).