

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

COMMENCE 0002/IP     SUSPEND 0002/S4

Board Claim No. <b>0005</b>	Employee Last Name <b>0043</b>	Employee First Name <b>0044</b>	M.I. <b>0045</b>	Social Security Number <b>0042</b>	Date of Injury <b>0031</b>
--------------------------------	-----------------------------------	------------------------------------	---------------------	---------------------------------------	-------------------------------

### A. IDENTIFYING INFORMATION

<b>EMPLOYEE</b>		Name of Claimant / Guardian			
Address <b>0046 0047</b>		City <b>0048</b>	State <b>0049</b>	Zip Code <b>0050</b>	
<b>INSURER / SELF-INSURER</b>	Name <b>0007 0006</b>		<b>EMPLOYER</b>	Name <b>0018</b>	
<b>CLAIMS OFFICE</b>	Name <b>0188 0187</b>		Address <b>0019 0020</b>		Phone Number <b>0159</b>
Address <b>0010</b>		Phone Number			
		Insurer/Self-Insurer File # <b>0015</b>			
City <b>0012</b>	State <b>0013</b>	Zip Code <b>0014</b>	SBWC ID # (five digit number) <b>N/A</b>		City <b>0021</b>
				State <b>0022</b>	Zip Code <b>0023</b>
Claims E-mail			Employer E-mail		

### B. DEATH BENEFITS

1. Benefits will be paid at the rate of \$ **0134** \*per week based on an average weekly wage of \$ **0286** ,  
 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 **0057** / \_\_\_\_ / \_\_\_\_

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

2. Benefits will be suspended on **0193** because: **0002/S4**  
**0233**

### 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

2 (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	