

# 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.	SSN or Board Tracking #	Date of Injury
-----------------	--------------------	---------------------	------	-------------------------	----------------

## A. CLAIM INFORMATION

<b>EMPLOYEE</b>	Birthdate	County of Injury	Address		
Employee E-mail			City	State	Zip Code
<b>EMPLOYER</b>	Name		<b>INSURER/ SELF-INSURER</b>	Name	SBWC# (five digit #)
Address			<b>CLAIMS OFFICE</b>	Name	
			Claims Address		
City	State	Zip Code	City	State	Zip Code
Employer E-mail			Claims E-mail		
<b>ATTORNEY FOR EMPLOYEE/CLAIMANT</b>	Name		<b>ATTORNEY FOR EMPLOYER/INSURER</b>	Name	
Address		GA Bar Number	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
-------------------------	------------------------	--

## B. HEARING / MEDIATION ISSUES

<input type="checkbox"/> Income Benefits	<input type="checkbox"/> TTD(Dates) _____	<input type="checkbox"/> Medical Benefits	List Benefits
	<input type="checkbox"/> TPD(Dates) _____	<input type="checkbox"/> Suspension / Termination Request	Effective Date
	<input type="checkbox"/> PPD(Dates) _____	Reason	
<input type="checkbox"/> Late-Payment 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		
<input type="checkbox"/> Catastrophic Designation	Specify		
<input type="checkbox"/> Appeal of Rehabilitation Decision	Specify		
<input type="checkbox"/> Other	Specify		
<input type="checkbox"/> 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 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).