GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ WC-1 Dated _____

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☐ SUSPEND ☐ AMENDMENT

☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury
0005	**0043**	**0044**	**0004**	**0042**	**0031**

A. IDENTIFYING INFORMATION

EMPLOYEE 0053	Employee E-mail	**EMPLOYER**	Name **0018**
Address **0168**		Address **0019**	
		City **0021**	State **0022** / Zip Code **0023**
City **0165**	State **0170** / Zip Code **0167**	Employer E-mail	
INSURER/ SELF- INSURER	Name **0007**	Address **0010**	
CLAIMS OFFICE	Name **0188**	City **0012**	State **0013** / Zip Code **0014**

Insurer/Self-Insurer File #	Claims Office E-Mail	Phone Number	SBWC ID# (five digit no.)
0134	**0138**	**0137**	

B. INCOME BENEFITS

☐ Benefits are being paid to this employee at the rate of $ **0286** * per week based on an average weekly wage of $ **0134** payable from **0088** for: _____

☐ Temporary Total Disability

☐ Temporary Partial Disability

☐ Permanent Partial Disability of **0084** % to **0083** to be paid for **0090** weeks (**medical report attached**).

☐ Date of Disability **0056**

The date of the first check is, **0195** , the amount is $ **0218** , or date salary was paid **0195 (0085 + 00273)** and this:

☐ Does not include penalty

☐ Does include

a **0218** % penalty in the amount of $ **0310 or 0311**

*File Form WC-6, Wage benefits, if weekly beneifts is less than maximum.

C. SUSPENSION OF BENEFITS

☐ Benefits will be suspended on **0193** because :

☐ 1.) Employee returned to work on **0072/0224** without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on **0072/0224** with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on **0072/0224** with restrictions from the authorized treating physician at reduced pay of $ **0124** per week and temporary partial disability benefits are shown in Part B above.

☐ 4.) Employee was able to return to work on **0068** without restrictions from the authorized treating physician, the employee is being given (10) days notice, and the authorized treating physician's report is attached (Board Rule 221).

☐ 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 a 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 offered employee has been offerred 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.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKER'S 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 PER VIOLATION (O.C.G.A. § 34-9-18 AND §34-9-19).

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C. SUSPENSION OF BENEFITS CONTD.

☐ 8.) The entire permanent partial disability benefit has been paid. *Reason codes S7*

☐ 9.) The maximum of temporary partial disability payments has been paid. *Reason codes S7*

☐ 10.) This claim has been controverted within sixty days of the due date of first payment. **A copy of the Form WC-3 is attached and a copy was sent to the employee.**

☐ 11.) Other: *S8 > transfer to another jurisdiction*

Insurer/Self-Insurer Type or Print Name **0007**	Signature	Date
Phone Number and ext.	Email	