GEORGIA STATE BOARD OF WORKERS' COMPENSATION

CREDIT

Instructions: When seeking credit/reimbursement pursuant to O.C.G.A. §34-9-243, the employer shall file this form with the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299, and send a copy to all counsel and unrepresented parties immediately upon seeking credit, and in any event no later than 10 days prior to a hearing.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address			
Employee E-mail		City	State	Zip Code	
EMPLOYER	Name	**INSURER/ SELF-INSURER**	Name		
Mailing Address		**CLAIMS OFFICE**	Name		
		SBWC ID# (five digit no)	E-mail		
City	State / Zip Code	Mailing Address			
Employer E-mail	Phone Number	City	State	Zip Code	

B. CREDIT REQUESTED

1. A credit is requested as allowed by O.C.G.A. §34-9-243 for benefits paid under the "Employment Security Law" or employer funded portions of payments received by the employee pursuant to:
   - ❑ Unemployment compensation payments
   - ❑ Wage continuation plan
   - ❑ Disability plan
   - ❑ Disability insurance policy
2. The employee has been paid weekly benefits of $ _____ , from the date of _____ / _____ / _____ through _____ / _____ / _____ , for which credit is sought.
3. The ratio of the employer's contributions to the total contributions of the plan or policy is _____ %. The amount of credit per week will be calculated as follows: $ _____ (weekly disability benefit per plan or policy) X _____ (Ratio of contributions) % = $ _____ (to be credited against TTD or TPD benefits due.)

Credit shall not exceed the amount of income benefits due the employee.

C. CERTIFICATE OF SERVICE

❑ I hereby certify that the above information is true and correct to the best of my knowledge and a copy of this form has been sent to the Board, to counsel, and to all unrepresented parties in this claim.

Print Name Here	Signature	Date

Phone	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).