

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, 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
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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
<p>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:</p> <p> <input type="checkbox"/> Unemployment compensation payments <input type="checkbox"/> Wage continuation plan <input type="checkbox"/> Disability plan <input type="checkbox"/> Disability insurance policy </p> <p>2. The employee has been paid weekly benefits of \$ _____, from the date of _____ / _____ / _____ through _____ / _____ / _____, for which credit is sought.</p> <p>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:</p> $ \begin{array}{ccccccc} \$ & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & \% = & \$ & \underline{\hspace{2cm}} \\ & \text{(weekly disability benefit} & & \text{(Ratio of contributions)} & & & \text{(to be credited against TTD} \\ & \text{per plan or policy)} & & & & & \text{or TPD benefits due)} \end{array} $ <p>Credit shall not exceed the amount of income benefits due the employee.</p>

C. CERTIFICATE OF SERVICE		
<input type="checkbox"/> 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.sbcw.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).