

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ INITIAL PAYMENT ☐ RE-COMMENCE ☐ SUSPEND ☐ AMENDMENT: ☐ WC-1 Dated **0002/02**
0002/IP/EP/PY **0002/RB/CB/RE** **0002/Sx/CB/PY** **0002/02** ☐ WC-2 Dated **0002/02**

Board Claim No. 0005	Employee Last Name 0043, 0255	Employee First Name 0044	M.I. 0045	Social Security Number 0042	Date of Injury 0031
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A. IDENTIFYING INFORMATION

EMPLOYEE		Employee E-mail N/A		EMPLOYER		Name 0018 0016	
Address 0046 0047				Address 0019 0020			
				City 0021	State 0022	Zip Code 0023	
City 0048	State 0049	Zip Code 0050		Employer E-mail			
INSURER/ SELF-INSURER		Name 0007 0006		Address 0010 0011			
CLAIMS OFFICE		Name 0188 0187		City 0012	State 0013	Zip Code 0014	
Insurer/Self-Insurer File # 0015	Claims Office E-mail			Phone Number		SBWC ID# (five digit no.)	

B. INCOME BENEFITS

☐ Benefits are being paid to this employee at the rate of \$ **0134** *per week based on an average weekly wage of \$ **0062**
 payable from **0088** / / for:
☐ Temporary Total Disability **0085/050**
☐ Temporary Partial Disability **0085/070 File WC-262**
☐ Permanent Partial Disability of **0084** % to **0083** to be paid for **0090** weeks (medical report attached).
0085/030 (Part of Body)
☐ Date of Disability **0056 or 0144**
 The date of the first check is, / **0192** / **PY/0195**, the amount is \$ **PY/0218 0086**, or date salary was paid **0273/Y** / / **0056** and this:
☐ Does not include a penalty
☐ Does include a **15** % penalty in the amount of \$ **0216 = 310/0215**.
 *File Form WC-6, Wage Statement, if weekly benefit is less than maximum.

C. SUSPENSION OF BENEFITS

☐ Benefits will be suspended on **0193** / **PY/0195** / because:
☐ 1.) Employee returned to work on **0224/N** / **S1** / **0068 / 0072** without restrictions from the authorized treating physician.
☐ 2.) Employee returned to work on **0224/Y** / **S1** / **0068 / 0072** with restrictions from the authorized treating physician at pre-injury or higher rate of pay.
☐ 3.) Employee returned to work on **0224/Y** / **CB** / **0068/ 0072** with restrictions from the authorized treating physician at reduced pay of \$ **File WC-262 every 13 weeks after CB** per week and temporary partial disability benefits are shown in Part B above.
☐ 4.) Employee was able to return to work on **0224/N** / / **S2** without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221). **File Medical Report with a copy of WC-2**
☐ 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 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. 0224/Y RE File WC-104 and WC-262 and copy of WC-2 in paper**
☐ 6.) The employee has been offered 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. S3 File WC-240 and WC-2**
☐ 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid. **S7 (050)**
☐ 8.) The entire permanent partial disability benefit has been paid. **S7 (030)**
☐ 9.) The maximum of temporary partial disability payments has been paid. **S7 (070)**
☐ 10.) This claim is being 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: **10.) SD also file 04 with DN0198 = 2x or 3x 11.) S4 0146=N, S5, S6, and S8**

Insurer/Self-Insurer Type or Print Name 0188	Signature	Date 0003
Phone Number and ext.	E-mail 0138	

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