WC-2 NOTICE OF PAYMENT / SUSPENSION OF BENEFITS

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

0 INITIAL PAYMENT IP/EP/PY | 0 RE-COMMENCE RB/CB/RE/ER | 0 SUSPEND Sx/CB/PY | 0 AMENDMENT: 02

0 WC-1 Dated 0003/00/AU

0 WC-2 Dated 0003/IP/EP/AP

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

A. IDENTIFYING INFORMATION

EMPLOYEE	Employee E-mail: N/A	**EMPLOYER**	Name: 0018 0016
Address: 0046 0047		Address: 0019 0020	
City: 0048	State: 0049 / Zip Code: 0050	City: 0021 / State: 0022 / Zip Code: 0023	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

0 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:

0 Temporary Total Disability 0085/050

0 Temporary Partial Disability 0085/070 File WC-262

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

0085/030

0 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:

0 Does not include a penalty

0 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 DN0197

0 Benefits will be suspended on 0193 / PY/0195 / _____ because:

0 1.) Employee returned to work on 0224/N / S1 / 0068 / 0072 without restrictions from the authorized treating physician.

0 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.

0 3.) Employee returned to work on 0224/Y / S1/ CB / 0068 with restrictions from the authorized treating physician at reduced pay of $ File WC-262 every 13 weeks after filing S1 0285/0124 per week and temporary partial disability benefits are shown in Part B above.

0 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

0 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 CB File WC-104 and copy of WC-2 in paper

0 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

0 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid. S7 (050)

0 8.) The entire permanent partial disability benefit has been paid. S7 (030)

0 9.) The maximum of temporary partial disability payments has been paid. S7 (070)

0 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**.

0 11.) Other: 10.) SD also file 04 with DN0198 = 2F or 3x 11.) S4 0146=N Death not result of injury, S5, S6, and S8 or PY/0293

Insurer/Self-Insurer Type or Print Name	Signature	Date
0188		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