GEORGIA STATE BOARD OF WORKERS' COMPENSATION

APPLICATION FOR LUMP SUM / ADVANCE PAYMENT

❑ APPLICATION ❑ OBJECTION

When you receive this completed form, you must file any objection with the Board within 15 days of the date on the certificate of service (O.C.G.A. §9-11-6(e)). If no response is received within the 15 day period, the Board will assume that the request is unopposed. Send to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299

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

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Mailing Address		
		City	State	Zip Code

B. APPLICATION OR OBJECTION

SELECT ONE OF THE FOLLOWING THREE OPTIONS:

❑ The employer/insurer agrees to this lump sum/advance. Complete sections C, D and F only. No attachments necessary

❑ The employee requests an advance and the employer/insurer does not agree to this lump sum/advance request.

❑ This is an objection to a lump sum/advance filed by the employee. Complete section C and F and attach documents in support of objection. Complete all sections and attach all applicable documents.

C. AGREEMENT

❑ The employer/insurer agrees to advance $ _____, subject to credit, as noted above, including credit for interest at 5% per annum, unless otherwise agreed to and allowed by law. (sign below if consented to).

Insurer	SBWC ID # (five digit no.)	Telephone Number	E-mail

Signature of Employer/Insurer	Title	Date

D. AFFIDAVIT

❑ Weekly income benefits have been paid to the employee for 26 or more weeks.

❑ The employee would like a lump sum payment of all remaining income benefits. The employee understands that benefits will be commuted at 5% interest per annum

❑ The employee would like an advance payment of a part of remaining income benefits in the amount of the $ _____. This advance will be repaid by:

- ❑ Credit to be taken when PPD is commenced (an actual or projected PPD rating must be attached) or upon settlement.
- ❑ Reducing the amount of weekly benefits by $ _____ (a current medical report must be attached).

The Employee is: ❑ Married ❑ Single ❑ Divorced ❑ Separated

The employee has _____ dependents. Their names, ages and relationships to the claimant are:

The employee needs this payment because: _____ the employee will use this money to do the following:
(list the specific bills or purchases for which you need the money.)

❑ I state under oath that all of the information is correct on both sides of this document, and that all additional information requested is attached.

❑ The employee hereby authorizes their attorney to receive a lump sum payment of $ _____ (not to exceed $500.00 or 25% of advance, whichever is less, unless specifically authorized by the Board).

❑ The employee's attorney is waiving any claim for attorney's fees on this advance.

Signature of Claimant

Sworn to and subscribed before me this _____ day of _____ (Month) / _____ (Year) .

Notary Public _____ My Commission Expires: _____ (Month) / _____ (Year)

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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

E. STATEMENT OF MONTHLY EXPENSES AND INCOME

EXPENSES			List Expenses per month	List all past due amounts
House Rent (or Mortgage Payment)			$	$
Groceries			$	$
Clothing			$	$
Child Care Expenses			$	$
Medical and Dental (Not Workers' Comp. Related)			$	$
School Expenses			$	$
Utilities (Gas, Electricity, Water, Telephone)			$	$
Loans for Car, Furniture, etc.				
Date/Loan	Name of Creditor	Balance Due	$	$
Date/Loan	Name of Creditor	Balance Due	$	$
OTHER EXPENSES				
		TOTAL EXPENSES	$	$

INCOME		
Claimant's Workers' Compensation Benefits	$	$
Social Security Payment of Claimant	$	$
Other Income of Claimant	$	$
Income of Spouse	$	$
Income of Other Family Members Living with Claimant	$	$
TOTAL INCOME		

Attach a current medical report (completed within the last 60 days) stating your physical status, extent and duration of disability, and permanent disability rating.
Also attach a copy of past due bills, a copy of estimates on any matter for which you are requesting this payment, if applicable, and other relevant documents, or your request will be denied.

F. CERTIFICATE OF SERVICE

❑ I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation and to all parties and counsel in this claim.

NOTE: Good faith effort to resolve issues means employer/insurer have had an opportunity to agree to advance before the request was submitted to the Board.

This _____ day of _____ (Month) / _____ (Year)

Signature of Claimant or Attorney	E-mail	GA Bar Number

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).