WC-14 NOTICE OF CLAIM

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

**Check only one:** ☐ **NOTICE OF CLAIM ONLY** ☐ **REQUEST FOR HEARING / NOTICE OF CLAIM** ☐ **REQUEST FOR MEDIATION / NOTICE OF CLAIM**

**Complete a new Form WC-14 to add an additional employer, insurer or to add date of injury.**
**If you need additional space, do not alter this form, but instead attach additional sheets. Must be typed or printed in black ink.**

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

## A. CLAIM INFORMATION

| **EMPLOYEE** | Birthdate | County of Injury | Mailing Address | | |
|---|---|---|---|---|---|
| Employee E-mail | | | City | State | Zip Code |

| **EMPLOYER** | Name | | **INSURER/ SELF- INSURER** | Name | SBWC# (five digit #) |
|---|---|---|---|---|---|
| Mailing Address | | | Mailing Address | | |
| City | State | Zip Code | City | State | Zip Code |
| Employer E-mail | | | Insurer E-mail | | |

| **ATTORNEY FOR EMPLOYEE/CLAIMANT** | Name | | **ATTORNEY FOR EMPLOYER/INSURER** | Name | |
|---|---|---|---|---|---|
| Mailing Address | GA Bar Number | | Mailing Address | GA Bar Number | |
| City | State | Zip Code | City | State | Zip Code |
| Attorney E-mail | | | Attorney E-mail | | |

| 1. Part of Body Injured | 2. First Date Disabled | 3. If Fatal – Enter complete date of death<br>Claimants for death benefits (list names & addresses) attach additional sheets |
|---|---|---|
| | | |

4. Description of Accident

## B. HEARING / MEDICATION ISSUES

☐ Income Benefits ☐TTD(Dates) ☐TPD(Dates) ☐PPD(Dates)

☐ Medical Benefits List Benefits:

☐ Suspension / Termination Request Effective Date

Reason:

☐ Dependency Benefits ☐ Burial Expenses

☐ Penalties / Assessed Attorney Fees
☐§34-9-221e ☐§34-9-108b (1) ☐§34-9-108b(2) ☐Other

☐ Request for Catastrophic Designation Specify:

☐ Appeal of Rehabilitation Decision Specify:

☐ Other Hearing Issues Specify:

Additional Board Claim Numbers which will be involved (if any):
☐ _____
(Complete a separate form WC14 for each date of accident)

## C. AFFIRMATION OF FILING PARTY

☐ I, [the person whose name appears above], attest and affirm that all information contained herein is true and correct to the best of my knowledge. I understand that knowingly giving false information to obtain or deny workers' compensation benefits subjects me to civil and criminal penalties.

## D. ENTRY OF APPEARANCE

☐ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102. (fee contract or WC-102B has been previously filed or is attached)

## E. CERTIFICATE OF SERVICE

☐ I hereby certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

| Print Name | Signature | Date |
|---|---|---|
| | | |

| Phone Number | 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).**



**For injuries occurring on or after July 1, 2007, any claim filed with the Board for which neither medical nor income benefits have been paid shall stand dismissed with prejudice by operation of law if no hearing has been held within five years of the alleged date of injury. (O.C.G.A. § 34-9-100)**