WC-14 GEORGIA STATE BOARD OF WORKERS' COMPENSATION
(7/92) *FOR BOARD USE ONLY
*

NOTICE OF

CLAIM/REQUEST FOR HEARING *Have File____________ *
*No File _____________ *
Entered/Computer _____

INSTRUCTIONS:
1) If you are an employee or a dependent of a deceased employee and you want to file a claim and to also request a hearing in order to obtain benefits, fill out parts A, B, and C below and on the back. If you already have, at some time in the past, filed a claim with the State Board of Workers' Compensation in this case and you now want a hearing in order to obtain benefits, fill out parts A and C below and on the back. If you fill out parts A and B only and sign on the back, a hearing will not be scheduled. If you are an employer or insurer and you want to suspend benefits to an employee or dependent, fill out parts A and C below and on the back.
2) Sign this on the back. If you have an attorney, he or she may sign on your behalf. The State Board of Workers' Compensation does not require you to have an attorney. Send a copy to all counsel and unrepresented parties.
3) Send this, plus 5 extra copies of both sides, to the State Board of Workers' Compensation, Suite 1000 - South Tower, One CNN Center, Atlanta, Georgia 30303-2788.
4) Do not send a cover letter to the Board. The Board will mail a notice to all parties.
5) If you need assistance in filling out this form, you may call the State Board of Workers' Compensation in Atlanta at (404) 656-3818 or 1-800-533-0682 [toll free].
6) If you do not know the name of the employer's insurance company, you may call (404) 656-3692 or 1-800-743-5436 [toll free] to see if the information has been recorded with the State Board of Workers' Compensation.

A. IDENTIFYING INFORMATION

_____________________________________ ( ) ___________ ______________________
Employee's Name (First) (Middle) (Last) Employee's Phone Number Social Security Number

____ ___/___/_______________
Employee's Street Address City State ZIP Date of Injury

_____________________________________ ( ) ___________ _____________________
Employer's Complete Legal Name Employer's Phone Number
County of Accident State

____
Employer's Address City County State Zip

____
Name of insurer (for workers' compensation) for employer on date of injury

* *

B. NOTICE OF CLAIM

1. ________________________________ 2a. ___/____/______ 2b. _____/______/___
Part(s) of Body Injured First Date Disabled Date of death
(if applicable)

4. Briefly describe the accident. ____

* *

C. REQUEST FOR HEARING

___ by Employee ____ by Employer ___ by Claimant(s) for death benefits:
___ by Other: ____ by Insurer (list names and addresses)

Since you are asking for a hearing in order to obtain benefits or relief,
you must provide additional information on the back of this form.

WC-14(Back) C. - continued -
(7/92)

__ INCOME BENEFITS: If you want income benefits, identify here the type of benefits you want (total disability benefits[TD], temporary partial disability benefits[TPD], or permanent partial disability benefits[PPD]) and the specific dates for which they are requested.

__MEDICAL BENEFITS: If you are requesting medical benefits, list the specific amounts of each bill and the names of the providers of services. [You may attach one extra sheet if necessary. Do not send copies of bills to the Board.] If you are requesting mileage, provide a summary of the trips.

__ ASSESSED ATTORNEY FEES/PENALTIES: State the legal ground and list the code sections which support your request. If the basis for this request is failure to comply with an order or award, give the date it was issued.

__ REASON FOR SUSPENSION/TERMINATION REQUEST: If you want to suspend or terminate the benefits of an employee or claimant, specify the reason here.

__ OTHER:

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I certify that I have today sent a copy of this
If an attorney is signing to all counsel and unrepresented parties. The this, type here

the name, names of counsel to whom this has been sent are: address and telephone number:

_____

Signature Date