



**Indemnification Commission
Application for Benefits**

Please check: Death _____ Total Permanent Disability _____ Supplemental _____
Partial Permanent Disability _____

Please print or type

EMPLOYEE INFORMATION

Full Name _____
Last First Middle

Social Security # _____ - _____ - _____ Marital Status _____

Date of Birth _____

Date of Accident ____/____/____ Date of Death/Disability ____/____/____

At the time of accident employee was (choose one):

_____ Paid Full-Time _____ Paid Part-Time _____ Volunteer

Gross Wages/Salary at time of Accident
\$ _____

Net Wages/Salary at time of Accident
\$ _____

_____ Position _____ Organization
_____ City, State, Zip _____ (Area Code) Telephone Number

_____ Immediate Supervisor

Name Address and Phone Number of WORKERS
COMPENSATION ADMINISTRATOR: _____

CLAIM INFORMATION

If claim is being filed for disability benefits complete Part A; if for death benefits complete Part B.

Description of Accident _____

CONTINUED ON BACK

A. DISABILITY CLAIMS

Please state the nature of the disability: _____
If a Guardian has been appointed, list that person's name, address, and telephone number, and attach copies of documents appointing them as Guardian:

If you are applying for supplemental pay benefits you must list all sources of compensation provided by your employer.

B. DEATH CLAIMS

Please list the name, address, and telephone number of the surviving spouse. Although not required by law, if applicable, please list any person appointed as Administrator or Executor and attach copies of documents appointing them as Administrator or Executor:

PREFERRED METHOD OF PAYMENT (please check one):

_____ Lump-Sum (at present value) _____ Monthly Installments

AUTHORIZED SIGNATURE

I do hereby certify that I am the Employee/Administrator/Executor, Spouse, and Dependent and that all information contained herein is accurate and truthful to the best of my knowledge. I authorize the release of any investigative or medical information, including that pertaining to any Workers' Compensation claim, necessary to process this claim. I do hereby certify that I have disclosed all sources of compensation and authorized DOAS to receive records associated with such sources of compensation.

This _____ day of _____ 20____ Signature _____

Name _____ Address _____

Business Telephone _____

Home Telephone _____

APPLICATION FOR BENEFITS MUST BE RECEIVED BY THE COMMISSION WITHIN 24 MONTHS FROM DATE OF ACCIDENT FOR PERMANENT DISABILITIES/DEATH AND 60 DAYS FOR SUPPLEMENTAL PAY.

Return Completed Application To:

Georgia State Indemnification Program
200 Piedmont Ave, SE, Suite 1220 West
Atlanta, Georgia 30334