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:

_____

Please list name, address, and telephone number of all of all physicians or other medical care providers treating the conditions causing disabilities.

_____

_____

_____

_____

_____

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