



Georgia State Indemnification Program

Application for (TBI) Total Permanent Disability Benefits

Please type or print

EMPLOYEE INFORMATION

Full Name _____
Last First Middle

Marital Status _____

Date of Birth _____

Date of Accident ___/___/_____

Date of Traumatic Brain Injury Diagnosis ___/___/_____

At the time of disability was (choose one):

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

_____ Position _____ Organization

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

Immediate Supervisor
Email: _____

Name, Address, Email, and Phone Number of
Workers' Compensation Administrator: _____

CLAIM INFORMATION

Description of Accident _____

CONTINUED ON NEXT PAGE

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 physicians and other medical care providers treating the conditions causing disabilities.

Applicants who previously supplied these documents in an earlier application do not need to resend the documents. The program DOES need you to complete this application form.

PREFERRED METHOD OF PAYMENT (please check one):

_____ Lump Sum (at present value) _____ Monthly Installments

AUTHORIZED SIGNATURE

I do hereby certify that I am the Applicant or Guardian of the Applicant, 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 the Georgia Department of Administrative Services to receive records associated with such sources of compensation.

This _____ day of _____ 20_____ Signature _____

Name _____ Address _____

Email Address _____

Home Telephone _____

APPLICATION FOR BENEFITS MUST BE RECEIVED BY THE GEORGIA DEPARTMENT OF ADMINISTRATIVE SERVICES WITHIN July 1, 2026, to August 1, 2026.

Return Completed Application To: Georgia State Indemnification Program
200 Piedmont Avenue, S.E., Suite 1208, West Tower
Atlanta, GA 30334

Or Email Application To: Marcellina.Scott@doas.ga.gov, and risk.management@doas.ga.gov.