Georgia State Indemnification

Application for Benefits

Please check: Death _____ Permanent Disability _______ Supplemental _____

Please type or print

EMPLOYEE INFORMATION

Full Name ____________________ ____________________ ____________________
Last First Middle

Marital Status _______________

Date of Birth ____________________

Date of Accident ____/_____/______ Date of Death/Disability ____/_____/______

At the time of the accident 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
Email:

Name, Address, Email, and Phone Number of Workers Compensation Administrator: ___________________________________
____
____

CLAIM INFORMATION

If claim is being filed for disability benefits complete Part A; if for benefit 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 physicians and 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, surviving children, and/or surviving dependents.

____

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/ Surviving Spouse/Child/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 ______________________________ Email____________________________

APPLICATION FOR BENEFITS MUST BE RECEIVED BY THE GEORGIA DEPARTMENT OF ADMINISTRATIVE SERVICES WITHIN 24 MONTHS FROM DATE OF ACCIDENT FOR PERMANENT DISABILITIES, DEATH, AND/OR 60 DAYS FOR SUPPLEMENTAL PAY.

Return Completed Application To:

Georgia State Indemnification
200 Piedmont Avenue, Suite 1220 West Tower
Atlanta, GA 30334