

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## APPLICATION/OBJECTION FOR LUMP SUM / ADVANCE PAYMENT

APPLICATION       OBJECTION

When you receive this completed form, you must file any objection with the Board within 15 days of the date on the certificate of service (O.C.G.A. §9-11-6(e)). If no response is received within the 15 day period, the Board will assume that the request is unopposed. Send to the State Board of Workers' Compensation, 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury
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### A. IDENTIFYING INFORMATION

<b>EMPLOYEE</b>	County of Injury	Address		
		City	State	Zip Code

### B. STATEMENT OF MONTHLY EXPENSES AND INCOME

EXPENSES	List Expenses per month	List all past due amounts		
House Rent (or Mortgage Payment)	\$	\$		
Groceries	\$	\$		
Clothing	\$	\$		
Child Care Expenses	\$	\$		
Medical and Dental (Not Workers' Comp. Related)	\$	\$		
School Expenses	\$	\$		
Utilities (Gas, Electricity, Water, Telephone)	\$	\$		
Loans for Car, Furniture, etc.				
Date/Loan	Name of Creditor	Balance Due	\$	\$
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<b>OTHER EXPENSES</b>			\$	\$
<b>TOTAL EXPENSES</b>			\$	\$

INCOME				
Claimant's Workers' Compensation Benefits		\$		\$
Social Security Payment of Claimant		\$		\$
Other Income of Claimant		\$		\$
Income of Spouse		\$		\$
Income of Other Family Members Living with Claimant		\$		\$
<b>TOTAL INCOME</b>				

Attach a current medical report (completed within the last 60 days) stating your physical status, extent and duration of disability. Also attach a copy of past due bills, a copy of estimates on any matter for which you are requesting this payment, if applicable, and other relevant documents, or your request will be denied.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwgc.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

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## C. AFFIDAVIT

- Weekly income benefits have been paid to the employee for 26 or more weeks.
- I would like a lump sum payment of all remaining income benefits. I understand that benefits will be commuted at 5% interest per annum.
- I would like an advance payment of a part of remaining income benefits in the amount of \$ \_\_\_\_\_. This advance will be repaid by:
  - Credit to be taken when PPD is commenced (an actual or projected PPD rating must be attached) or upon settlement.
  - Reducing the amount of weekly benefits by \$ \_\_\_\_\_ (a current medical report must be attached.)

I am:  Married  Single  Divorced  Separated.

I have \_\_\_ dependents. Their names, ages and relationships to the claimant are:

I need this payment because: \_\_\_\_\_ I will use this money to do the following:  
(list the specific bills or purchases for which you need the money.)

- I state under oath that all of the information is correct on both sides of this document, and that all additional information requested is attached.
- I hereby authorize my attorney to receive a lump sum payment of \$ \_\_\_\_\_ (not to exceed \$500.00 or 25% of advance, whichever is less, unless specifically authorized by the Board).
- My attorney is waiving any claim for attorney's fees on this advance.

Signature of Claimant	SSN or Board Tracking #	Date of Injury
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Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_ / \_\_\_\_\_ .  
(Month) (Year)

Notary Public \_\_\_\_\_ My Commission Expires: \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Year)

## Section D - Objection

- The employer/insurer does not agree to this request. (If this is an objection, attach documents in support of objection)

## Section E - Agreement

- The employer/insurer agrees to advance \$ \_\_\_\_\_, subject to credit, as noted above, including credit for interest at 5% per annum, unless otherwise agreed to and allowed by law. (sign below if consented to).

Insurer	SBWC ID # (five digit no.)	Telephone Number	E-mail
Signature of Employer/Insurer		Title	Date

## F. CERTIFICATE OF SERVICE

- I hereby certify that the parties have made a good faith effort to reach agreement on this issue, but have failed to do so to date. I further certify that I have this day sent a copy of this form with supporting documentation to the State Board of Workers' Compensation and to all parties and counsel in this claim.  
 NOTE: Good faith effort to resolve issues means employer/insurer has had an opportunity to agree to advance before the request was submitted to the Board.

This \_\_\_\_\_ day of \_\_\_\_\_ / \_\_\_\_\_ .  
(Month) (Year)

Signature of Claimant or Attorney	E-mail	GA Bar Number
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