**Client Alert**

Timeless Values. Progressive Solutions.

# File the 1 in *Every* One

Effective Jan. 1, 2019, the Board will require that a WC-1 be filed in all claims, regardless of whether income benefits are paid or not. Previously, a WC-1 was not required to be filed in "medical only" claims. Pursuant to O.C.G.A. § 34-9-12(a), the WC-1 must be filed within 10 days of the employer's notice of the accident. While this change does not take effect for another six months, Swift Currie recommends getting into the habit of doing so now so that it is a regular practice by Jan. 1, 2019. Keep in mind that failure to file Board forms, including the WC-1, could subject you to attorney's fees or civil penalties. Please see the sample WC-1 form below.

If you wish to discuss this change or have any questions, please contact a Swift, Currie, McGhee & Hiers attorney at 404.874.8800 or via our website, swiftcurrie.com

*The foregoing is not intended to be a comprehensive analysis of the full effect of these changes. Nothing in this notice should be construed as legal advice. This document is intended only to notify our clients and other interested parties about important recent developments. Every effort has been made to ascertain the accuracy of the information contained within this notice.*

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WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

## GEORGIA STATE BOARD OF WORKERS' COMPENSATION

### EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

**NOTE: FAILURE TO SUBMIT THIS REPORT TO INSURER IMMEDIATELY MAY RESULT IN PENALTY. MUST BE TYPED OR PRINTED IN BLACK INK.**

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

**A. IDENTIFYING INFORMATION**

**EMPLOYEE** | ☐ Male ☐ Female | Birthdate | Phone Number | Employee E-mail

Address | City | State | Zip Code

**EMPLOYER** | Name | NAICS Code | Nature of Business (Trade, Transport, Mfg.,etc.)

Address | Phone Number | Employer FEIN

City | State | Zip Code | Employer E-mail

**INSURER / SELF-INSURER** | Name | Insurer/Self-Insurer FEIN | Insurer/ Self-Insurer File #

**CLAIMS OFFICE** | Name | Claims Office FEIN # | Claims Office Phone | Claims Office E-mail

SBWC ID# (five digit no.) | Address | City | State | Zip Code

**EMPLOYMENT/WAGE** | Date Hired by Employer | Job Classified Code No. | Number of Days Worked Per Week | Wage rate at time of Injury or Disease: ☐ per Hour ☐ per Day ☐ per Week ☐ per Month

Insurer Type Code ☐I – Insurer ☐S-Self-insurer ☐Group Fund | List Normally Scheduled Days Off

**INJURY/ILLNESS & MEDICAL** | Time of Injury ☐ am ☐ pm | County of Injury | Date Employer had knowledge of Injury | Enter First Date Employee Failed to Work a Full Day

Did Employee Receive Full Pay on Date of Injury? ☐ Yes ☐ No | Did Injury/Illness Occur on Employer's premises? ☐ Yes ☐ No | Type of Injury/Illness | Body Part Affected

How Injury or Illness / Abnormal Health Condition Occurred

Treating Physician (Name and Address) | Initial Treatment Given: ☐ None ☐ Minor: By Employer ☐ Minor: Clinical/Hospital ☐ Emergency Room ☐ Hospitalized > 24hrs | Hospital / Treating Facility (Name and Address) | If Returned to Work, Give Date: | Returned at what wage per Week | If Fatal, Enter Complete Date of Death

Report Prepared By (Print or Type) | Telephone Number | Date of Report

☐ **B. INCOME BENEFITS** **Form WC-6 must be filed if weekly benefit is less than maximum**

Previously Medical Only ☐ Yes ☐ No | Average Weekly Wage: $ ________ Weekly benefit: $ ________ | Date of disability:

Date of first Payment: ________ Compensation paid: $ ________ or Date salary paid: ________ Penalty paid: $ ________

BENEFITS ARE PAYABLE FROM ________ FOR:

☐ Temporary total disability ☐ Temporary partial disability ☐ Permanent partial disability of ______ % to ________ for ______ weeks.

UNTIL ________ WHEN THE EMPLOYEE ACTUALLY RETURNED TO WORK WITHOUT RESTRICTIONS. ALL OTHER SUSPENSIONS REQUIRE THE FILING OF FORM WC-2 WITH THE STATE BOARD OF WORKERS' COMPENSATION AND THE EMPLOYEE.

☐ **C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION**

Benefits will not be paid because:

☐ **D. MEDICAL ONLY INJURY** **(No indemnity benefits are due and/or have NOT been controverted.)**

Insurer / Self-Insurer: Type or Print Name of Person Filing Form | Signature | Date

Phone Number | E-mail

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.sbwc.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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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

### NOTICE TO EMPLOYER

1. Provide prompt medical attention; allow the employee to select a physician from your posted panel, and explain the panel to the employee.
2. Complete Section A of this form immediately upon your knowledge of an injury and send the WC-1 to your insurance company or self-insurer claims office. **FAILURE TO DO SO MAY RESULT IN A PENALTY.** Do not send this form to the State Board of Workers' Compensation.
3. If you need additional help, call your insurance company or self-insurer claims office.
4. Report serious injuries immediately by telephone to your insurer's claims department, then file this form with your insurance company or self-insurer claims office.

### NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D. This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Section B: completed when indemnity benefits are paid. Section C: completed when claim is controverted. Section D: completed when no indemnity benefits are due and/or have NOT been controverted. Form W-6 must be filed if weekly benefits are less than the maximum.

### NOTICE TO EMPLOYEE

1. This form is provided for your information only.

   If Section B is completed, you will receive income benefits on a weekly basis and the employer will pay medical expenses from approved doctors. If you do not receive payment of benefits, or medical bills are not paid, call your employer or your employer's insurance company or self-insurer claims office.

   If Section C is completed, your claim of injury has been denied by the employer/insurer. If you disagree with this denial, you must file a form WC-14, Notice of Claim, within one year of the accident with the **State Board of Workers' Compensation, 270 Peachtree Street N.W., Atlanta, Georgia 30303-1299.**

   If Section D is completed, you will receive medical benefits only. At this time, indemnity benefits are not due. If your medical bills are not paid, call your employer or your employer's insurance company or self-insured claims office.

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

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