

# JOHNSON & BRYAN

## CLAIMS REPORTING PROCEDURES

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NO ONE LIKES TO INCUR LOSSES, BUT THEY DO OCCUR. THE FOLLOWING INSTRUCTIONS SHOULD FACILITATE YOUR REPORTING OF AUTOMOBILE, GENERAL LIABILITY, PROPERTY AND WORKERS' COMPENSATION CLAIMS. PLEASE REVIEW THIS MATERIAL CAREFULLY.

**ALL CLAIMS, EXCEPT WORKERS COMPENSATION CLAIMS, SHOULD BE REPORTED DIRECTLY TO OUR OFFICE.** PLEASE ASK TO SPEAK WITH LANETTE POPE TO REPORT YOUR CLAIM. IF YOU PREFER, YOU MAY FAX THE APPROPRIATE INFORMATION SHEET (FORMS INCLUDED IN THIS MANUAL) TO THEIR ATTENTION TO REPORT YOUR CLAIM.

YOUR CLAIM WILL BE REPORTED TO THE INSURANCE COMPANY IMMEDIATELY. THE CLAIM WILL BE FOLLOWED FOR TIMELY AND EFFICIENT HANDLING. SHOULD YOU HAVE QUESTIONS REGARDING THE CLAIM ONCE IT HAS BEEN REPORTED, PLEASE CALL OUR OFFICE.

THE AUTOMOBILE, GENERAL LIABILITY, AND PROPERTY FORMS INCLUDED OUTLINE THE INFORMATION NECESSARY TO REPORT AN INCIDENT. **PLEASE MAKE COPIES OF THESE FORMS AND KEEP A SUPPLY ON HAND.** DO NOT FEEL THAT EVERY PIECE OF INFORMATION REQUESTED HAS TO BE OBTAINED BEFORE A CLAIM CAN BE REPORTED. IF YOU ARE UNABLE TO OBTAIN ALL OF THE INFORMATION, REPORT WHAT YOU KNOW AS SOON AS POSSIBLE. EITHER JOHNSON & BRYAN'S CLAIM DEPARTMENT CAN FOLLOW UP FOR THE INFORMATION OR THE ADJUSTER ASSIGNED BY YOUR INSURANCE COMPANY CAN OBTAIN THE NECESSARY INFORMATION. THE MOST IMPORTANT FACTS THAT ARE NEEDED ARE: WHERE THE LOSS OCCURRED, WHEN IT OCCURRED, HOW IT HAPPENED, AND WHO WAS INJURED OR WHAT PROPERTY WAS DAMAGED.

IF AN ON-THE-JOB INJURY SHOULD OCCUR, COMPLETE A **FIRST REPORT OF INJURY FORM** AND FORWARD **THE ORIGINAL** DIRECTLY TO YOUR WORKERS' COMPENSATION CARRIER. WE HAVE INCLUDED AN INITIAL SUPPLY OF FORMS AND/OR AN ALTERNATE REPORTING METHOD—PLEASE REVIEW IT. FORWARD A **COPY** OF THE FIRST REPORT OF INJURY TO JOHNSON AND BRYAN'S CLAIM DEPARTMENT. **WE DO NOT NEED COPIES OF MEDICAL BILLS OR REPORTS THAT WILL FOLLOW; THESE SHOULD BE FORWARDED DIRECTLY BY YOU OR THE TREATING PHYSICIAN TO YOUR CARRIER. PROVIDE THEM WITH THE CORRECT ADDRESS.**

FEEL FREE TO CONTACT JOHNSON & BRYAN'S CLAIM DEPARTMENT ANYTIME YOU HAVE A QUESTION REGARDING CLAIM REPORTING PROCEDURES OF IF YOU HAVE A QUESTION ABOUT A CLAIM THAT HAS ALREADY BEEN TURNED IN.

WE HAVE INCLUDED AN OUTLINE OF THE MOST RECENT CHANGES IN THE GEORGIA WORKERS' COMPENSATION LAW. PLEASE REVIEW THIS INFORMATION AND FEEL FREE TO CALL SHOULD YOU HAVE QUESTIONS.

ALSO INCLUDED IS A SAMPLE OF AN EMPLOYEE/EMPLOYER JOB DESCRIPTION FORM. YOU MAY WANT TO MODIFY THIS FORM FOR YOUR COMPANY'S INDIVIDUAL NEEDS. THE IMPORTANT THING TO REMEMBER IS THAT THE FORM SHOULD BE DETAILED REGARDING WHAT DUTIES A PARTICULAR POSITION WILL REQUIRE. DO NOT ASK ABOUT PARTICULAR ILLNESSES OR DISABILITIES THE PROSPECTIVE EMPLOYEE MAY HAVE.

ACCORDING TO THE AMERICAN DISABILITY ACT, AN EMPLOYER MAY NO LONGER INQUIRE IF AN APPLICANT HAS DISABILITIES. YOU MAY, AFTER A JOB OFFER HAS BEEN EXTENDED AND ACCEPTED, REQUIRE A PHYSICAL AT THE COMPANY'S EXPENSE. IF A MEDICAL PROBLEM IS FOUND TO EXIST AND NO REASONABLE ACCOMMODATIONS CAN BE MADE TO ALLOW THE EMPLOYEE TO DO THE OFFERED JOB, AS THE EMPLOYER, TO MAKE REASONABLE ACCOMMODATIONS FOR THE NEW EMPLOYEE. THE MEDICAL CONDITION MUST PREVENT THE EMPLOYEE FROM PERFORMING THE DESCRIBED JOB DUTIES. KNOWLEDGE OF AN EXISTING CONDITION IS NOT SUFFICIENT REASON TO WITHDRAW THE OFFER. HOWEVER, AN EXISTING MEDICAL PROBLEM CAN BE NOTED IN THE EMPLOYEE'S FILE AND USED FOR NOTICE TO THE GEORGIA SUBSEQUENT INJURY FUND IF INJURY OCCURS ON THE JOB, AND AGGRAVATES OR IS CAUSED DUE TO AN EXISTING MEDICAL PROBLEM.

# NOTICE TO EMPLOYERS

## CHANGES IN GEORGIA WORKERS' COMPENSATION LAW

EFFECTIVE JULY 1, 2002, SEVERAL CHANGES HAVE BEEN TAKEN PLACE IN THE WORKERS' COMPENSATION LAW IN GEORGIA. AS AN EMPLOYER, YOU NEED TO BE AWARE OF THESE CHANGES AND HOW THEY AFFECT YOU. THESE CHANGES AFFECT ONLY ACCIDENTS OCCURRING ON OR AFTER JULY 1, 2002. THEY ARE AS FOLLOWS:

### MEDICAL PANEL CARD

**THERE MUST BE SIX, NON ASSOCIATED PHYSICIANS POSTED  
OF THE SIX**

**THERE MUST BE ONE ORTHOPEDIC SPECIALIST THERE  
CANNOT BE MORE THAN TWO INDUSTRIAL CLINICS. IF  
FEASIBLE, A MINORITY PHYSICIAN SHOULD BE INCLUDED.**

- THE MAXIMUM WEEKLY BENEFIT FOR TEMPORARY TOTAL AND PERMANENT PARTIAL DISABILITY WILL INCREASE TO **\$400.00 PER WEEK**. ON TEMPORARY TOTAL BENEFITS FROM THE INJURY DATE ON NON-CATASTROPHIC CASES.

THE MAXIMUM WEEKLY BENEFIT FOR TEMPORARY PARTIAL DISABILITY WILL INCREASE TO **\$268.00 PER WEEK**.. THE MAXIMUM DEATH BENEFIT PAID TO A SOLE, DEPENDENT SPOUSE IS **\$125,000**.

### RIGHTS, BENEFITS AND OBLIGATIONS

**THE LAW REQUIRED THE STATE BOARD TO PROVIDE A  
SUMMARY OF THE RIGHTS, BENEFITS AND OBLIGATIONS TO  
EACH EMPLOYER IN THE STATE. WHEN THIS IS RECEIVED,  
THE EMPLOYER MUST POST THIS ALONGSIDE THE PANEL OF  
PHYSICIANS.**

**WE HAVE ENCLOSED THE "BILL OF RIGHTS FOR THE INJURED  
WORKERS' NOTICE. PLEASE POST IT IMMEDIATELY.**

- **SUBROGATION**

SUBROGATION HAS BEEN REINSTATED WITH CERTAIN LIMITATIONS. EMPLOYERS CAN EXPECT TO BE CONTACTED IN SOME CIRCUMSTANCES BY CLAIM REPRESENTATIVES INVESTIGATING THE POSSIBILITY OF THIRD-PARTY NEGLIGENCE CONTRIBUTING TO OR CAUSING ACCIDENTS.

- **SETTLEMENTS**

AN INSURER IS NOT AUTHORIZED TO SETTLE A CLAIM ON BEHALF OF AN INSURED EMPLOYER WITHOUT GIVING PROPER NOTICE TO THE EMPLOYER OF THE TERMS OF THE SETTLEMENT. **THIS DOES NOT REQUIRE CONSENT BY THE EMPLOYER, ONLY THAT THE EMPLOYER BE NOTIFIED.** IN THE EVENT A WORKERS' COMPENSATION CLAIM SETTLEMENT IS ANTICIPATED, YOU WILL BE CONTACTED BY A CLAIM REPRESENTATIVE WHO WILL EXPLAIN THE DETAILS. PLEASE TAKE A FEW MINUTES TO REVIEW AND IMPLEMENT THESE CHANGES AS THEY PERTAIN TO YOUR OPERATION.

# JOHNSON & BRYAN

## AUTOMOBILE INFORMATION FORM

<b>INSURED:</b>					
<b>CONTACT PERSON:</b>					
<b>ADDRESS:</b>			<b>PHONE:</b>		
			<b>FAX:</b>		
<b>DATE OF OCCURRENCE:</b>			<b>TIME:</b>	<b>DAY:</b>	
<b>LOCATION OF ACCIDENT:</b>					
<b>INSURED'S DRIVER:</b>					
<b>DAY PHONE:</b>					
<b>INSURED VEHICLE INFORMATION:</b>			<b>YEAR:</b>	<b>MAKE:</b>	<b>VIN:</b>
<b>EXTENT OF DAMAGE TO INSURED VEHICLE:</b>					
<b>LOCATION OF INSURED VEHICLE:</b>					
<b>OTHER VEHICLE OWNER:</b>					
<b>DAY PHONE:</b>			<b>HOME PHONE:</b>		
<b>DRIVER:</b>					
<b>OTHER VEHICLE INFORMATION:</b>			<b>YEAR:</b>	<b>MAKE:</b>	<b>VIN:</b>
<b>INSURANCE COMPANY:</b>			<b>POLICY NUMBER:</b>		
<b>EXTENT OF DAMAGE TO OTHER VEHICLE:</b>					
<b>LOCATION OF OTHER VEHICLE:</b>					
<b>POLICE DEPARTMENT:</b>			<b>CASE NUMBER:</b>		
<b>ANYONE CITED?</b>			<b>CITATIONS:</b>		
<b>ANY INJURIES?</b>			<b>WHO AND WHERE TREATED?</b>		
<b>WITNESSES?</b>			<b>NAME AND PHONE:</b>		
<b>DATE REPORT COMPLETED:</b>			<b>DATE NOTIFIED OF INCIDENT:</b>		
<b>REPORT COMPLETED BY:</b>			<b>DAY PHONE:</b>		
<b>DESCRIPTION OF ACCIDENT:</b>					

**REPORT ALL CLAIMS TO:**  
**LANETTE A. POPE**  
**TEL: (404) 351-8434    FAX: (404) 351-3923**



# JOHNSON & BRYAN

## PROPERTY LOSS INFORMATION FORM

<b>INSURED:</b>	<b>CONTACT PERSON:</b>
<b>INSURED ADDRESS:</b>	<b>PHONE:</b>
	<b>FAX:</b>
<b>LOCATION OF DAMAGE:</b>	
<b>CAUSE OF DAMAGE:</b>	
<b>DATE OF OCCURRENCE:</b>	
<b>WEATHER CONDITIONS:</b>	
<b>EXTENT OF DAMAGE:</b>	<b>AUTHORITIES CONTACTED:</b>
<b>HAVE ANY REPAIRS BEEN STARTED?</b>	

**REPORT ALL CLAIMS TO:  
LANETTE A. POPE  
TEL: (404) 351-8434  
FAX: (404) 351-3923**

# JOHNSON & BRYAN

<b>GENERAL LIABILITY ACCIDENT INFORMATION FORM</b>			
<b>INSURED:</b>			
<b>INSURED CONTACT PERSON:</b>		<b>PHONE:</b>	
<b>INSURED ADDRESS:</b>			
<b>CENTER NAME (IF APPLICABLE):</b>			
<b>LOCATION ADDRESS (IF OTHER THAN ABOVE):</b>			
<b>DATE OF OCCURRENCE:</b>		<b>TIME:</b>	<b>DAY:</b>
<b>LOCATION WHERE ACCIDENT OR INJURY OCCURRED (OUTSIDE, PARKING LOT, ETC.)</b>			
<b>DID PERSON REQUIRE MEDICAL ATTENTION AT THE SCENE:</b>		<b>TO WHAT EXTENT?</b>	
<b>WAS PERSON TAKEN TO HOSPITAL OR EMERGENCY FACILITY?</b>		<b>WHICH?</b>	
<b>NAME OF INJURED PERSON/OWNER OF DAMAGED PROPERTY:</b>		<b>DAMAGED PROPERTY:</b>	
<b>ADDRESS:</b>			
<b>DAYTIME PHONE:</b>		<b>HOME PHONE:</b>	
<b>WITNESS NAME:</b>		<b>DAYTIME PHONE:</b>	
<b>ADDRESS:</b>			
<b>DATE REPORT COMPLETED:</b>			
<b>REPORT COMPLETED BY:</b>		<b>DAYTIME PHONE:</b>	
<b>DESCRIPTION OF ACCIDENT:</b>			
REPORT ALL CLAIMS TO LANETTE A. POPE TEL: (404) 351-8434    FAX: (404) 351-3923			



# MEMORANDUM FOR PERSONNEL FILE

RE: ON-THE-JOB INJURIES

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This is to certify that you have reviewed the official notice of the Panel of Physicians.

If you are injured at work, we will pay medical expenses within the limits of the Workers' Compensation law so long as certain rules are followed. First, you must tell us of your injury immediately so we may help you contact a doctor and get you cared for. You must choose a doctor from the list of doctors contained on the pink panel form posted on the employee bulletin board. You may change to another doctor on our posted panel once, if you wish, without our authorization. However, before you change again, you must get our approval or approval from the State Board of Workers' Compensation.

If you desire to obtain medical services from a physician not listed on the Panel, you may do so; however, you will be liable for those medical expenses.

In the case of an emergency, you should go to the nearest emergency room. However, all follow-up care must, thereafter, be rendered by a physician from the Panel, or a Panel Physician's referral.

You further understand that you must notify your supervisor as soon as the injury occurs, regardless of the extent of the injury. Delay in notification may result in denial of payment for medical services rendered.

Failure to abide by these requirements will result in our refusal to pay for your medical treatment because it was unauthorized.

Please sign below indicating that you have read this, and that any questions concerning these rights and obligations have been answered.

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Signature of Employee

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Date

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Print Name of Employee

cc: Employee

**AUTHORIZATION**  
**TO RELEASE MEDICAL INFORMATION**

TO: DR. \_\_\_\_\_

RE: NAME OF EMPLOYEE: \_\_\_\_\_

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I hereby authorize you to release any and all medical information pertaining to my case history and physical or mental condition which you may have, including your conclusions regarding my health, to \_\_\_\_\_ and/or any of its subsidiaries for use by officials of the company(ies).

I hereby release you from all legal responsibility or liability that may arise from the act which I have authorized above.

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Signature of Employee

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Date

# EMPLOYEE JOB DESCRIPTION

EMPLOYEE: \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

NOTE: IN TERMS OF AN 8-HOUR WORKDAY

OCCASIONALLY = 1% TO 33%

FREQUENCY = 34% TO 66%

CONTINUOUSLY = 67% TO 100%

I EMPLOYEE IS REQUIRED TO (CIRCLE FULL CAPACITY FOR EACH ACTIVITY)										
A	SIT	NUMBER OF HOURS	1	2	3	4	5	6	7	8
B	STAND	NUMBER OF HOURS	1	2	3	4	5	6	7	8
C	WALK	NUMBER OF HOURS	1	2	3	4	5	6	7	8

II ON THE JOB EMPLOYEE MUST	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A. BEND/STOOP				
B. SQUAT				
C. CRAWL				
D. CLIMB				
E. REACH ABOVE SHOULDER LEVEL				
F. CROUCH				
G. KNEEL				
H. BALANCING				
I. PUSHING/PULLING				

III ON THE JOB EMPLOYEE LIFTS	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A. UP TO 10 POUNDS				
B. 11 TO 24 POUNDS				
C. 25 TO 34 POUNDS				
D. 35 TO 50 POUNDS				
E. 51 POUNDS TO 74 POUNDS				
F. 75 POUNDS TO 100 POUNDS				
IV ON THE JOB EMPLOYEE CARRIES	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
A. UP TO 10 POUNDS				

B. 11 TO 24 POUNDS				
C. 25 TO 34 POUNDS				
D. 35 TO 50 POUNDS				
E. 51 POUNDS TO 74 POUNDS				
F. 75 POUNDS TO 100 POUNDS				

V. INJURED WORKERS CAN USE FEET FOR REPETITIVE MOVEMENTS AS IN OPERATING FOOT CONTROLS					
RIGHT		LEFT		BOTH	
YES	NO	YES	NO	YES	NO

VII. DOES JOB REQUIRE		COMMENTS
A. WORKING ON UNPROTECTED HEIGHTS		
YES	NO	
B. BEING AROUND MOVING MACHINERY		
YES	NO	
C. EXPOSURE TO MARKED CHANGES IN TEMPERATURE AND HUMIDITY		
YES	NO	
D. DRIVING AUTOMOTIVE EQUIPMENT		
YES	NO	
E. EXPOSURE TO DUST, FUMES, GASSES		
YES	NO	
F. IS REGULAR WORK AVAILABLE?		
YES	NO	
G. IS LIGHT OR MODIFIED WORK AVAILABLE?		
YES	NO	

SIGNATURE OF EMPLOYEE: \_\_\_\_\_

DATE: \_\_\_\_\_

SIGNATURE OF EMPLOYER: \_\_\_\_\_

DATE: \_\_\_\_\_

TITLE: \_\_\_\_\_

PLEASE RETURN TO: \_\_\_\_\_

# **OCCUPATIONAL HEALTH HISTORY QUESTIONNAIRE**

*NOTE: THIS QUESTIONNAIRE IS ONLY TO BE FILLED OUT AFTER AN EMPLOYMENT OFFER HAS BEEN MADE.*

NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ SOCIAL SECURITY NO: \_\_\_\_\_ TELEPHONE NO: \_\_\_\_\_

YOUR DOCTOR'S NAME AND ADDRESS: \_\_\_\_\_

## **MEDICAL HISTORY QUESTIONNAIRE**

A. HAVE YOU EVER BEEN TREATED FOR	YES	NO		YES	NO
BACK INJURY/BACK SURGERY			ALCOHOL OR DRUG DEPENDENCE		
RUPTURE OR HERNIA			MUSCULAR WEAKNESS		
CONVULSIONS/EPILEPSY			HEART PROBLEMS/CHEST PAIN		
UNCORRECTABLE VISION/EYE INJURY			HEARING PROBLEM		
DIABETES/DIZZINESS			HEAD INJURY		
CARPAL TUNNEL SYNDROME					
B. PLEASE CHECK ANY OF THE FOLLOWING SUBSTANCES WHICH ARE PRESENT WHILE YOU WORK OR WITH WHICH YOU HAVE HAD CONTACT IN THE PAST:					
SOLVENTS (TOE, ALCOHOL, ETC.)			PHOTO MASK DEVELOPER		
METAL FUMES OR DUST			INSECT OR PLANT SPRAY, PESTICIDES		
TOXIC GASES			PLASTIC OR RESIN FUMES		
RADIATION (X-RAY, MICROWAVES, LASER)			CHEMICAL FUMES		
NOISE			ASBESTOS DUST		
SILICA OR SAND BLASTING DUST			IRRITATING GASES		
ACIDS, CAUSTICS, STRIPPERS			OTHERS		
IF ANSWERS ARE YES TO THE QUESTIONS BELOW - PLEASE EXPLAIN				YES	NO
C. HAVE YOU EVER FILED A COMPENSATION CLAIM OR RECEIVED MEDICAL BENEFITS?					
D. ARE YOU UNDER A DOCTOR'S CARE NOW?					
E. ARE YOU TAKING ANY DRUGS OR MEDICATIONS NOW?					
F. IS THERE ANY TYPE OF WORK YOU CANNOT OR SHOULD NOT DO BECAUSE OF A PHYSICAL CONDITION OR MEDICAL PROBLEM?					

G. DO YOU HAVE A PHYSICAL CONDITION OR MEDICAL PROBLEM THAT WOULD IMPACT YOUR ABILITY TO PROPERLY CARRY OUT THE DUTIES OF THIS JOB, OR MAY HAVE AN IMPACT ON OTHER WORKERS OR PROPERTY OF THE COMPANY?		
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I REALIZE THE STATUS OF MY HEALTH IS A SUBSTANTIAL FACTOR IN THE DECISION AS TO MY EMPLOYMENT AND I THEREFORE CERTIFY THAT ALL INFORMATION ON THIS APPLICATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE SIGNATURE:

DATE:



*(This document must be posted in a conspicuous place readily accessible to the employees at all times.)*

# OFFICIAL NOTICE

This business operates under the Georgia Workers' Compensation Law.

**WORKERS MUST REPORT ALL ACCIDENTS IMMEDIATELY TO THE EMPLOYER BY ADVISING THE EMPLOYER PERSONALLY. AN AGENT, REPRESENTATIVE, BOSS, SUPERVISOR, OR FOREMAN.**

If a worker is injured at work, the employer shall pay medical and rehabilitation expenses within the limits of the law. In some cases the employer will also pay a part of the worker's lost wages.

Work injuries and occupational diseases should be reported in writing whenever possible. The worker may lose the right to receive compensation if an accident is not reported within 30 days.

The employer will supply free of charge, upon request, a form for reporting accidents and will also furnish, free of charge, information about workers' compensation. The employer will also furnish to the employee, upon request, copies of board forms on file with the employer pertaining to an employee's claim.

A worker injured on the job must select a doctor from the list below. The minimum panel shall consist of at least four physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics. Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). Effective January 1, 2002,

The minimum panel shall consist of at least six physicians in addition to the requirements set forth above. The Board may grant exceptions to the required size of the panel where it is demonstrated that more than four physicians are not reasonably accessible. One change of doctor, from the list, may be made without permission. Further changes require the permission of the employer or the State Board of Workers' Compensation.

#### State Board of Workers' Compensation

270 Peachtree Street, N.W.  
Atlanta, Georgia 30303-1299  
404-656-3818  
or 1-800-533-0682  
<http://www.ganet.org/sbwc/>

\_\_\_\_\_  
name/address/phone

\_\_\_\_\_  
name/address/phone

\_\_\_\_\_  
name/address/phone

\_\_\_\_\_  
name/address/phone

\_\_\_\_\_  
name/address/phone

\_\_\_\_\_  
name/address/phone

(Additional doctors may be added on a separate sheet)

The insurance company providing coverage for this business under the Workers' Compensation Law is:

\_\_\_\_\_  
Name

\_\_\_\_\_  
address

\_\_\_\_\_  
phone

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).

WC-P1 (7/2001)

## **STATE BOARD OF WORKERS' COMPENSATION BILL OF RIGHTS FOR THE INJURED WORKER**

As required by law, O.C.G.A. §34-9-81.1, this is a summary of your rights and responsibilities. The Worker's Compensation Law provides you, as a worker in the State of Georgia, with certain rights and responsibilities should you be injured on the job. The Worker's Compensation Law provides you coverage for a work-related injury even if an injury occurs on the first day on the job. In addition to rights, you also have certain responsibilities. Your rights and responsibilities are described below.

### **Employee's Rights**

1. If you are injured on the job, you may receive medical rehabilitation and income benefits. These benefits are provided to help you return to work. Your dependents may also receive benefits if you die as a result of a job-related injury.
2. Your employer is required to post a list of at least four doctors or the name of the certified WC/MCO that provides medical care. Effective January 1, 2002, the employer is required to post a list of at least six doctors, unless the Board has granted an exception. You may choose a doctor from the list and make one change to another doctor on the list without the permission of your employer. However, in an emergency, you may get temporary medical care from any doctor until the emergency is over, then you must get treatment from a doctor on the posted list.
3. Your authorized doctor bills, hospital bills, rehabilitation in some cases, physical therapy, prescriptions, and necessary travel expenses will be paid if injury was caused by an accident on the job.
4. You are entitled to weekly income benefits if you have more than seven days of lost time due to an injury. Your first check should be mailed to you within 21 days after the first day you missed work. If you are out more than 21 consecutive days due to your injury, you will be paid for the first week.
5. Accidents are classified as being either catastrophic or non-catastrophic. Catastrophic injuries are those involving amputations, severe paralysis, severe head injuries, severe burns, blindness, or of a nature and severity that prevents the employee from being able to perform his or her prior work and any work available in substantial numbers within the national economy. In catastrophic cases, you are entitled to receive two-thirds of your average weekly wage but not more than \$400 per week for a job-related injury for as long as you are unable to return to work. You also are entitled to receive medical and vocational rehabilitation benefits to help in recovering from your injury. If you need help in this area call the State Board of Workers' Compensation at (404) 656-3875.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$400 per week for a job related injury. You will receive these weekly benefits as long as you are totally disabled, but no longer than 400 weeks, if you are not working and it is determined that you have been capable of performing work with restrictions for 52 consecutive weeks or 78 aggregate weeks, your weekly income benefits will be reduced to two-thirds of your average weekly wage but no more than \$268 per week, not to exceed 350 weeks.
7. When you are able to return to work, but can only get a lower paying job as a result of your injury, you are entitled to a weekly benefit of not more than \$268 per week for no longer than 350 weeks.
8. Your dependent(s), in the event you die as a result of an on-the-job accident, will receive burial expenses up to \$7,500 and two-thirds of your average weekly wage, but not more than \$400 per week. A widowed spouse with no children will be paid a maximum of \$125,000. Benefits continue until he/she remarries or openly cohabits with a person of the opposite sex.
9. If you do not receive benefits when due, the insurance carrier/employer must pay a penalty, which will be added to your payments.

### **Employee's Responsibilities**

1. You should follow written rules of safety and other reasonable policies and procedures of the employer.
2. You must report any accident immediately, but not later than 30 days after the accident, to your employer, your employer's representative, your foreman or immediate supervisor. Failure to do so may result in the loss of the benefits.
3. You must accept reasonable medical treatment and rehabilitation services when ordered by the State Board of Workers' Compensation or the Board may suspend your benefits.
4. No compensation shall be allowed for an injury or death due to the employee's willful misconduct.
5. You must notify the insurance carrier/employer of your address when you move to a new location. You should notify the insurance carrier/employer when you are able to return to full-time or part-time work and report the amount of your weekly earnings because you may be entitled to some income benefits even though you have returned to work.
6. A dependent spouse of a deceased employee shall notify the insurance carrier/employer upon change of address or remarriage.
7. You must attempt a job approved by the authorized treating physician even if the pay is lower than the job you had when you were injured. If you do not attempt the job, your benefits may be suspended.
8. If you believe you are due benefits and your insurance carrier/employer denies these benefits, you must file a claim within one year after the date of last authorized medical treatment or within two years of your last payment of weekly benefits or you will lose your right to these benefits.

The State Board of Workers' Compensation will provide you with information regarding how to file a claim and will answer any other questions regarding your rights under the law. If you are calling in the Atlanta area the telephone number is (404) 656-3818, outside the metro Atlanta area call 1-800-533-0682, or write the State Board of Workers' Compensation at: 270 Peachtree Street, N.W., Atlanta, Georgia 30303-1299. A lawyer is not needed to file a claim with the Board; however, if you think you need a lawyer and do not have your own personal lawyer, you may contact the Lawyer Referral Service at (404) 521-0777 or 1-800-237-2629.

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).

(7/2001)