WC-14 NOTICE OF CLAIM

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check only one: ☒ **NOTICE OF CLAIM ONLY** ☐ **REQUEST HEARING / NOTICE OF CLAIM** ☐ **REQUEST FOR MEDIATION / NOTICE OF CLAIM**

Complete a new Form WC-14 to add an additional employer, insurer or to add date of injury.

If you need additional space, do not alter this form, but instead attach additional sheets. Must be typed or printed in black ink.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
5467-2334-22	SUGGS	DENISE	L.	5/17/2023

A. CLAIM INFORMATION

EMPLOYEE	Birthdate: 2/11/1979	County of Injury: GWINETT	Mailing Address: 35545 EAGLE DRIVE			
Employee E-mail:			City: EMMERSON	State: GA	Zip Code: 30052	
EMPLOYER	Name: ACME CORP.		**INSURER/ SELF- INSURER**	Name: TRAVELERS INS.		SBWC# (five digit #): 64523
Mailing Address: 2003 RIVERSIDE PKWY			Mailing Address: ONE TOWER SQUARE			
City: LAWERENCEVILLE	State: GA	Zip Code: 300043	City: HARTFORD	State: CT	Zip Code: 06183	
Employer E-mail: jlawson@acmeinc.com			Insurer E-mail: wcclaims@travelers.com			
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name: DAVID SMITH		**ATTORNEY FOR EMPLOYER/INSURER**	Name:		
Mailing Address: 2457 CLUB DRIVE, STE 410	GA Bar Number: 432515		Mailing Address:	GA Bar Number:		
City: DULUTH	State: GA	Zip Code: 30096	City:	State:	Zip Code:	
Attorney E-mail: david@davesmithlaw.com			Attorney E-mail:			

1. Part of Body Injured	2. First Date Disabled	3. If Fatal – Enter complete date of death Claimants for death benefits (list names & addresses) attach additional sheets
BACK	5/17/2023	

4. Description of Accident: INJURED BACK ATTEMPTING TO LIFT HEAVY ITEM ONTO LOADING BELT

B. HEARING / MEDIATION ISSUES

☐ Income Benefits	☐TTD(Dates)	☒ Medical Benefits	List Benefits: HEALTH INSURANCE - GABCBS
	☐TPD(Dates)	☐ Suspension / Termination Request	Effective Date
	☐PPD(Dates)	Reason:	
☐ Dependency Benefits	☐ Burial Expenses		

☐ Penalties / Assessed Attorney Fees

☐§34-9-221e ☐§34-9-108b (1) ☐§34-9-108b(2) ☐Other

☒ Request for Catastrophic Designation	Specify:	☐ Appeal of Rehabilitation Decision	Specify:
☐ Other Hearing Issues	Specify:	Additional Board Claim Numbers which will be involved (if any): ☐ _____ (Complete a separate form WC14 for each date of accident)	

C. AFFIRMATION OF FILING PARTY

☒ I, [the person whose name appears above], attest and affirm that all information contained herein is true and correct to the best of my knowledge. I understand that knowingly giving false information to obtain or deny workers' compensation benefits subjects me to civil and criminal penalties.

D. ENTRY OF APPEARANCE

☒ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102. (fee contract or WC-102B has been previously filed or is attached)

E. CERTIFICATE OF SERVICE

☒ I hereby certify that I have today sent a copy of this form to all of the parties and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date
DAVID SMITH	/s/	6/19/2023

Phone Number	E-mail
770-325-2942	david@davesmithlaw.com

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).

For injuries occurring on or after July 1, 2007, any claim filed with the Board for which neither medical nor income benefits have been paid shall stand dismissed with prejudice by operation of law if no hearing has been held within five years of the alleged date of injury. (O.C.G.A. §34-9-100)