GEORGIA SUBSEQUENT INJURY TRUST FUND
Suite 500 North Tower
1720 Peachtree Street. NW
Atlanta, GA 30309-2462
NOTICE OF CLAIM

In support of such notice and without precluding the right to establish further facts as may be developed, the following allegations are set forth subject to proof at a Hearing.

EMPLOYER'S NOTICE OF CLAIM FOR REIMBURSEMENT FROM THE SUBSEQUENT INJURY TRUST FUND (Official Code of Ga. Ann. 34-9-362)	Soc. Sec. No. _____ Insurer File No. _____

Employee (Claimant Name) _____ Date of Injury _____

Address _____ (Use separate claim form for each injury date

Employer Name _____ ☐ Check if self-insured

Address _____

Insurer (as shown on policy) _____

Address _____ Tel. No. _____ Ext. _____

Details of Subsequent Injury
Description of Accident:
Nature of Injury:

Date Disability Began:
Current Status *(please check as many as apply):*

☐ Employee's claim has been controverted. ☐ Employee's claim is being settled.

☐ Employee's claim is in litigation. ☐ T.D. ☐ T.P. ☐ P.P. ☐RTW Date(s): ☐ Other:

ATTACHMENTS *(when available or with this filing)*:
(1) Pertinent narrative medical and rehabilitation reports.
(2) Copies of all pertinent workers' compensation Forms (WC-1, WC-2, WC-4, WC-6, R-1) and Awards.
☐ Check here if this report is ONLY to toll the Statute of Limitations AND for the purpose of protecting the employer's right to pursue this claim at a later date. (Attachments requested below are not required until claim is activated.)

Employer Notice Requirement (Official Code of Ga. Ann. 34-9-361).
State facts establishing employer's informed conclusion that the prior impairment is permanent and a hindrance to employment.

Employer must complete "Knowledge Affidavit" (S.I. "H"), according to Rule 622-1-.05.

Nature of Prior Impairment
Listed impairment (identify) per Official Code of Ga. Ann. 34-9-361 (1) through (23):

If "other" – identify:

ATTACHMENTS *(when available or with this filing)*:
Medical narratives that verify presence of prior permanent impairment.

Merger between Prior Impairment and Subsequent Injury (Official Code of Ga. Ann. 34-9-351).
☐ Employee's pre-existing condition caused the injury; or
☐ Combined with the subsequent injury to result in greater employer liability for medical and weekly income benefits.
☐ Accelerated death of the employee.

Average Weekly Wage $_____ Comp. Rate: $_____ Medical Expenses to date: $_____

Rehabilitation Expenses to date: $_____

Signed: _____

PRINT OR TYPE NAME: _____

Date: _____

Mailing Address

If you have a disability and need assistance in completing this form, please contact the Subsequent Injury Trust Fund's ADA coordinator at Suite 500, North Tower, 1720 Peachtree St. NW., Atlanta, GA 30309, Tel: (404) 206-6360; Fax (404) 206-6363; TDD No. (404) 206-5053; Website: www.sitf.georgia.gov