State of Georgia
Subsequent Injury Trust Fund

Fundamentals of Filing a Claim

Marquis II Tower, Suite 1250
285 Peachtree Center Ave. NE
Atlanta, GA 30303-1229

Tel: (404) 656-7000
Fax: (404) 656-7100
http://sitf.georgia.gov

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INTRODUCTION

Our Mission

The Subsequent Injury Trust Fund provides reimbursements and information to employers, insurers, and their agents, in those Workers' Compensation claims involving individuals with a pre-existing permanent impairment.

Our Vision

The Board of Trustees and staff of the Subsequent Injury Trust Fund commit to bringing awareness of the financial benefits available to employers, insurers, and their agents, by continuing our efforts to build positive relations in the risk management arena.

Our Goals

1. Work with clients and parties at interest on how to properly present claims.
2. Increase agency visibility among insurance agents and risk managers.
3. Build alliances with state agencies that provide employer-related services.
4. Empower all levels of staff with agency-related knowledge.

STAFF CONTACT

EXECUTIVE/ADMINISTRATION STAFF

Administrator, Mike Coan
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Supervisor, Barbara DeVeaux
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WC Specialist, Tressie Matthews
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WC Specialist, Bishop Tinsley
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WC Specialist, Phyllis Holt
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WC Specialist, Alethea Watt
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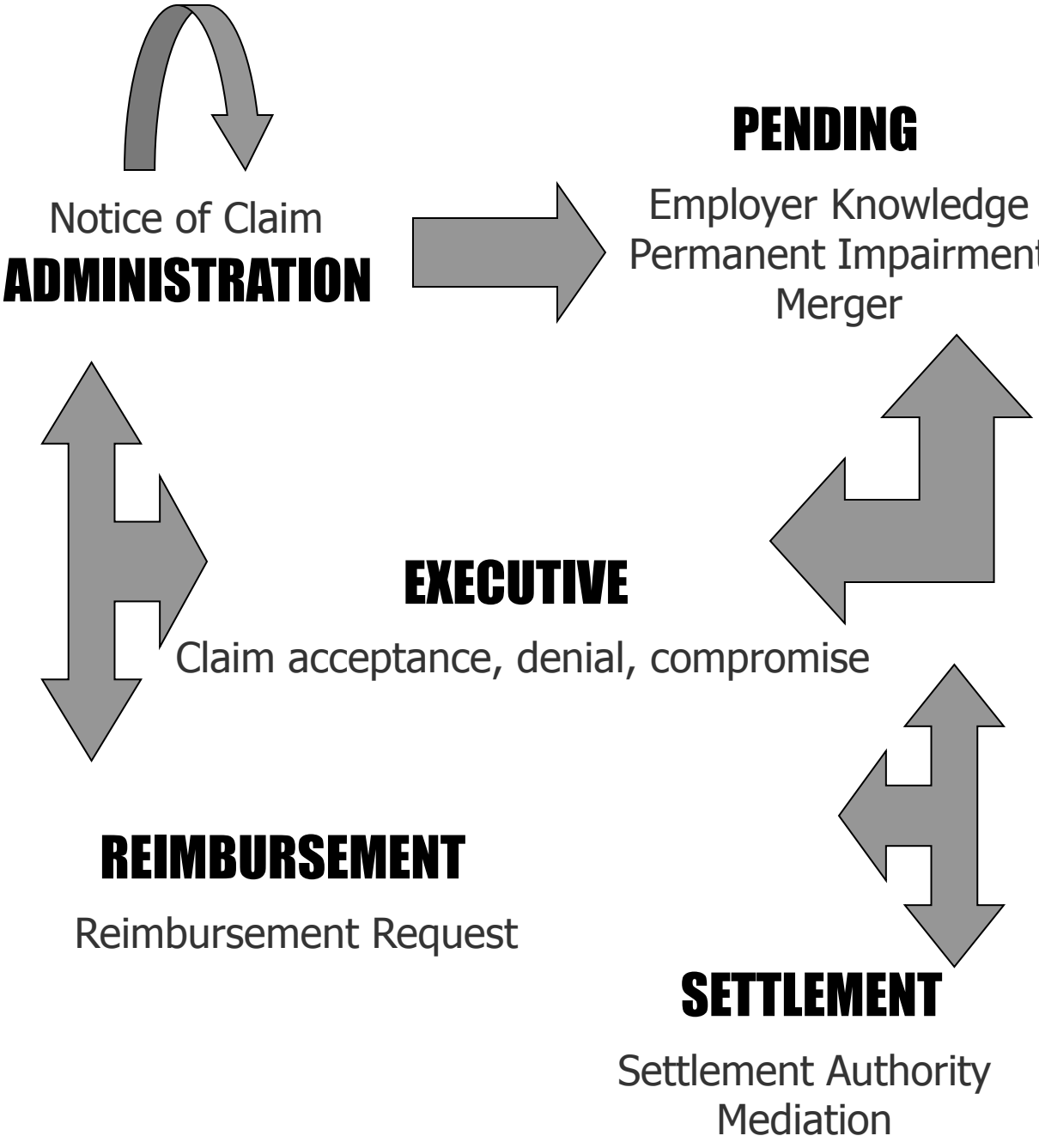
THE CLAIMS PROCESS



EXECUTIVE

<u>Board of Trustees</u>
John Fervier
James F. Braswell
E. Pauline Hale
John L. Quinn

Mike Coan, Administrator

Allan Payne, Deputy Administrator

SITF Board Decisions

Litigation

Stipulation Agreements

Rule Changes

Final Claim Approval

Policy Standards

LEGAL AUTHORITY

The legal authority for the Fund established by the General Assembly is published in Title 34, Chapter/Article 9 of the Official Code of Georgia.

http://www.legis.state.ga.us

34-9-350 – Purpose
34-9-351 – Definitions
34-9-351.1. – Authorized Self-Insurer
34-9-352 – Office of Treasury and Fiscal Services
34-9-353 – Surety Bond
34-9-354 – Board of Trustees
34-9-355 – Appointment of Administrator
34-9-356 – Expenses
34-9-357 – Budget
34-9-358 – Assessments
34-9-359 – Penalties and Fees
34-9-360 – Deductibles
34-9-361 – Presumed Permanent Impairment
34-9-362 – Notice of Claim
34-9-363 – State Board Approval
34-9-363.1 – Settlement
34-9-364 – Apportionment
34-9-365 – Effective Date of Injury
34-9-366 – Not a Party, Not Bound
34-9-367 – Attorney Fees
34-9-368 – Dissolution of the Fund

RULES & REGULATIONS

The Board of Trustees is authorized to amend SITF Rules and Regulations when appropriate.

The Rules are designed to inform insurance carriers, self-insurers, employers and employees about the Georgia Subsequent Injury Trust Fund (SITF) and to define the prerequisites and proper procedures for filing a claim with the fund.

622-1-.01 Board of Trustees

622-1-.02 Cost of Administration; Budget

622-1-.03 (1) Payment of Non-dependency Benefits into the SITF

622-1-.03 (2) Payment of Assessments to the Fund by Insurers and Self-Insurers

622-1-.03 (3) Reports by Employers of Compensation and Benefits Paid; Failure to Pay Assessments

622-1-.04 Filing Claims Against the Subsequent Injury Trust Fund

622-1-.05 Employer's Knowledge Statement

622-1-.06 Procedures for Payment of Reimbursement Benefits by the Fund

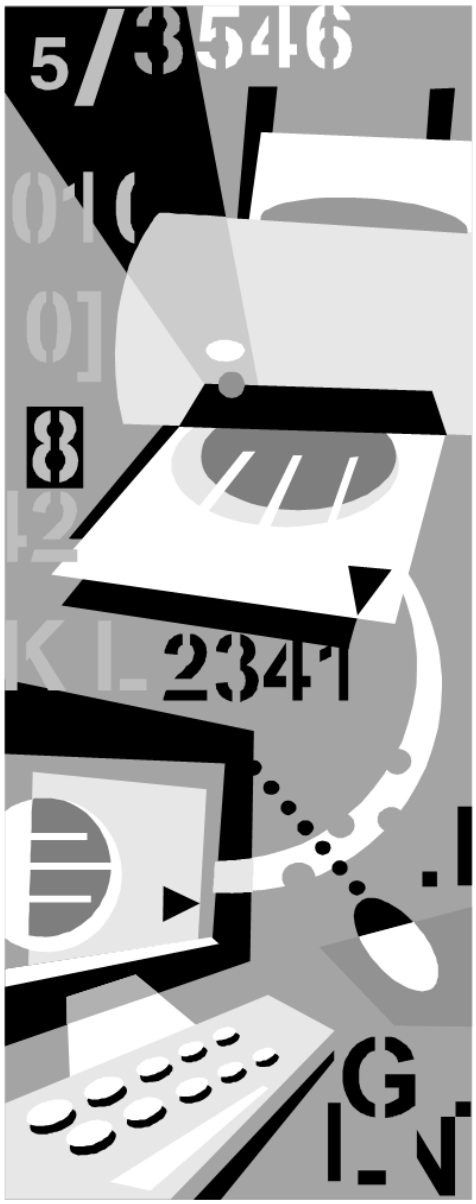
622-1-.07 Settlements Subsequent to Reimbursement Agreements

622-1-.08 Fund not Bound as to Certain Matters.

Visit our Website

http://sitf.georgia.gov

ADMINISTRATION



Notice of Claim

Auto-notification of claims filed

Incoming mail

Claims database

Open records requests

Claim status information

Reimbursement checks

Assessment collection

ADMINISTRATION STAFF

Kathy Cannon
404-656-7022
kcannon@sitf.ga.gov

Chris Perea
404-656-7027
cperea@sitf.ga.gov

NOTICE OF CLAIM

To reduce paper handling, SITF has made available an Online Notice of Claim Form.

Receipt notification of online filing is provided to the employer/insurer or servicing agent.

If you prefer to submit a claim form on paper, the form can be downloaded from the SITF website – http://sitf.georgia.gov

The employer/insurer should notify the Fund as soon as practicable of a possible claim, but no later than:

- payment of 78 weeks of income or death benefits, or
- within 78 calendar weeks from the date of injury – whichever occurs later. Also:
- the claim must be filed prior to final settlement.

Notice of Claim

Notice of Claim

GEORGIA SUBSEQUENT INJURY TRUST FUND
Marquis II Tower, Suite 1250
285 Peachtree Center Avenue
Atlanta, GA 30303
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: $_____

Signed: — Rehabilitation Expenses to date: $_____

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 Marquis II Tower, Suite 1250, 285 Peachtree Center Ave., Atlanta, GA 30303, Tel: (404) 656-7000; Fax (404) 656-7100; TDD No. (404) 656-7162; Website: www.sitf.georgia.gov

SI"A", 6/01

FILE ONLINE http://sitf.georgia.gov

PENDING

Assigns activated claims to Specialist

Review claim for proper documentation

Verifies Employer Knowledge

Verifies pre-existing permanent impairment

Verifies merger

Based on findings, recommends acceptance or denial of claim

Evaluates claim value

PENDING CLAIMS UNIT

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EMPLOYER KNOWLEDGE

The affiant must be someone who has firsthand knowledge of the injured worker's pre-existing condition such as an individual in an executive, personnel, or personnel-advisory capacity, or, if an employer is subject to the Americans With Disabilities Act, the designated custodian of (medical) records.

Attach any documentation or records that were in the employer's possession prior to the subsequent injury. If you attach documents, these must be accompanied by certification on employer's letterhead that states "documents were contained in employer's files".

Any reports specifically referred to in the affidavit must be attached and certified.

The employer should identify the actual date of knowledge of the prior impairment.

The employer, if possible, should list any individuals (along with their address and telephone number) either currently or formerly working for the employer who may have firsthand knowledge of the employee's pre-existing disability.

Employer's Knowledge Affidavit

Employer's Knowledge Affidavit

EMPLOYER'S KNOWLEDGE AFFIDAVIT

On _____ (Date of first knowledge), I _____ (Name), the _____ (Title)

for _____ (Employer), learned that _____ (Employee) SSN _____

had _____ (Type of prior impairment). I received this information in the

following manner: _____

_____

I considered it a permanent physical impairment because:_____

_____

In addition, I considered the impairment likely to be a hindrance to employment because:_____

_____

If this affidavit is prepared by someone other than the appropriate employer representative, please identify:

_____
Name

_____

NOTICE TO EMPLOYER:

If this document is pre-prepared and submitted to you for signature, carefully review this document to make sure the Information outlined is consistent with your knowledge of the prior impairment.

I, the undersigned employer representative, hereby provide the above information under oath.

_____
Employer Representative

_____
Title

_____ Telephone No.:_____
Notary Public

Expiration date:_____ Date:_____

IF YOU HAVE A DISABILITY AND NEED ASSISTANCE IN COMPLETING THIS FORM, PLEASE CONTACT THE SUBSEQUENT INJURY TRUST FUND'S ADA COORDINATOR AT MARQUIS II TOWER, SUITE 1250, 285 PEACHTREE CENTER AVE, ATLANTA, GA 30303, TELEPHONE NO. (404) 656-7000; FAX NO. (404) 656-7100; TDD NO. (404) 656-7162

WEBSITE: www.sitf.georgia.gov
IMPORTANT : See Reverse Side for Instructions

SI"H", 6/01

PERMANENT IMPAIRMENT

DEFINITION

Any permanent condition due to previous injury, disease, or disorder which is, or is likely to be, a hindrance or obstacle to employment or to obtaining reemployment if the employee should become unemployed.

DOCUMENTATION

- Prior Medical Reports
- Employee Personnel File
- Prior WC Injury Information
- Physical Evaluation File
- Pre-employment Physical Exam Documents
- Health Questionnaire

KNOWLEDGE

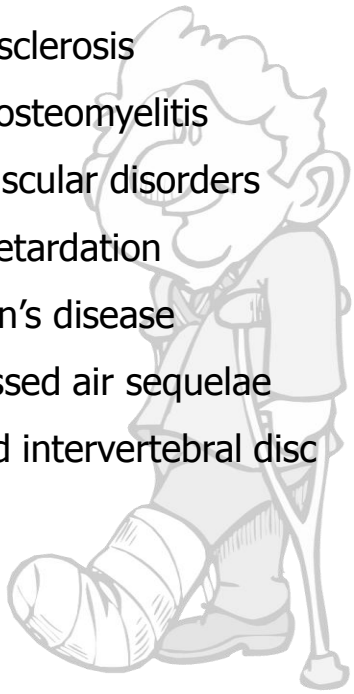
The EMPLOYER must reach an informed conclusion the the pre-existing condition is:

- Permanent in nature;
- Is likely to be a hindrance to employment; and
- Provide a letter certifying that information was in the employer's file PRIOR to the date of the subsequent injury.

PRESUMED CONDITIONS

There are 23 presumed conditions that are considered by law to be permanent and likely a hindrance to employment.

1. Epilepsy
2. Hyperinsulism
3. Diabetes
4. Tuberculosis
5. Hemophilia
6. Cerebral palsy
7. Muscular dystrophy
8. Psychoneurotic disability
9. Amputated foot, leg, arm, or hand
10. Residual disability from poliomyelitis
11. Ankylosis of major weight bearing joints
12. Total occupational loss of hearing (as defined in OCGA 34-9-264
13. Arthritis which is an obstacle or hindrance to employment
14. Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than 75% bilaterally
15. Any permanent condition which, prior to the occurrence of the subsequent injury, constitutes a 20% impairment of a foot, leg, hand, arm, or the body as a hole.
16. Sickle cell anemia
17. Multiple sclerosis
18. Chronic osteomyelitis
19. Cardiovascular disorders
20. Mental retardation
21. Parkinson's disease
22. Compressed air sequelae
23. Ruptured intervertebral disc



MERGER

MERGER CONDITIONS

Had the pre-existing permanent impairment not been present, the subsequent injury would not have occurred.

The disability resulting from the subsequent injury (in conjunction with the pre-existing permanent impairment) is materially, substantially, and cumulative greater than that which would have resulted had the pre-existing permanent impairment not been present, and the employer has been required to pay and has paid compensation for that greater disability; or

Death would not have been accelerated had the pre-existing permanent impairment not been present.

The Employer/Insurer must provide medical evidence supporting merger between the subsequent injury and the prior impairment.

CAUSAL MERGER

Had the pre-existing permanent impairment not been present, the subsequent injury would not have occurred.

EXAMPLE: Injured worker has epilepsy, she has a seizure, loses consciousness, falls and hits her head incurring severe head trauma.

If the employee had not had the permanent impairment, she would not have suffered the subsequent injury.

EXAMPLE: Injured worker has had a prior herniated disc at L4-5 with discectomy. While performing his normal job as a mechanic (routine twisting, turning, etc.), he experiences back pain. He is diagnosed with a "recurrent" herniated disc.

Because he had a permanent impairment, and did not have a specific event that caused the injury, this would still be considered a causal merger.

GREATER THAN MERGER

The disability resulting from the subsequent injury, in conjunction with, the pre-existing permanent impairment is materially, substantially, and cumulatively greater than that which would have resulted had the pre-existing permanent impairment not been present; and the employer, during the subsequent injury, must have paid compensation for that greater disability (not medical expenses).

EXAMPLE: The injured worker has diabetes. He/she steps on a nail and incurs a puncture wound to the foot. He/she subsequently develops osteomyelitis/infection and has to have several debridements or possibly a partial amputation.

The employer/insurer is required to pay or has paid for the greater disability which was the consequence of the claimant's pre-existing diabetes and the impact of the diabetes on the subsequent injury. If the claimant did not have the pre-existing diabetes, with the same injury and no complications, there would be no greater than merger.

NOTE: The permanency rating from the prior injury cannot be added to the permanency rating of the subsequent injury to create a greater disability.

COMBINED EFFECTS MERGER

COMBINED EFFECTS

This occurs only when the injured worker is totally unable to re-enter the workforce. The fund established this type merger in an effort to provide greater reimbursement possibilities.

The merger occurs when two separate impairments or areas of the anatomy do not directly "merge", but when combined, cause permanent and total disability to the injured worker.

EXAMPLE: An employee is totally blind in the left eye. He/she sustains an injury to the cervical spine and requires fusion. The employer has no work available for this person – the employee cannot do his/her regular job because of the cervical spine and cannot do "desk" work because of the blindness in the left eye. Therefore, because of the two separate impairments, the employee is totally and permanently disabled from the job resulting from the combined effects.

In the instance of a combined effects merger, all medical expenses will be apportioned (not paid). Only indemnity expenses, after proper deductibles are met, will be reimbursed.

REMEMBER: Merger must be substantiated by medical evidence.

The examples presented within this document are for illustrative purposes only; they are not case specific. Each SITF claim is reviewed on its own merits.

RETURN TO WORK

NO NEW DEDUCTIBLE APPLICATION

When a claim is accepted by the Fund and the injured worker returns to work with the same employer (with no break in service), the employer is not subject to additional indemnity or medical deductions if the employee suffers a new accident that merges with the same prior impairment.

The Fund operates as a tool to assist in the rehabilitation process and provides for reimbursement of allowable rehabilitation expenses.

REIMBURSEMENT AGREEMENT

1. The Reimbursement Agreement is a legally binding document and must be signed (on behalf of the employer and insurer) by someone with management or supervising authority.
2. Third party administrators cannot sign the Reimbursement Agreement.
3. Attorneys for the employer/insurer can sign the document.
4. The Fund creates, signs, and forwards the Reimbursement Agreement to the claim handler for signature by the insurer. Once the agreement is signed by both parties, the Fund forwards the document to the State Board of Workers' Compensation for approval. A copy of the Board approved Agreement is returned to the Fund and a copy is mailed to the claim handler.
5. A Board approved Agreement (identifying the proper payee) MUST be on file prior to payment on a SITF claim.

DENIED CLAIMS

The Fund will notify the employer/insurer if it is determined that a claim does not qualify for reimbursement.

When a claim is denied by the Fund, the employer/insurer must request a hearing with the State Board of Worker's Compensation – Form WC-14. The form must be submitted within 90 days of receipt of the denial notice and a copy must be forwarded to the Fund. This notice to the Board need not be a request for an immediate hearing, but meets statutory requirements and protects the employer/insurer's claim.

The Fund makes every attempt to resolve differences with the employer/insurer prior to a hearing date.

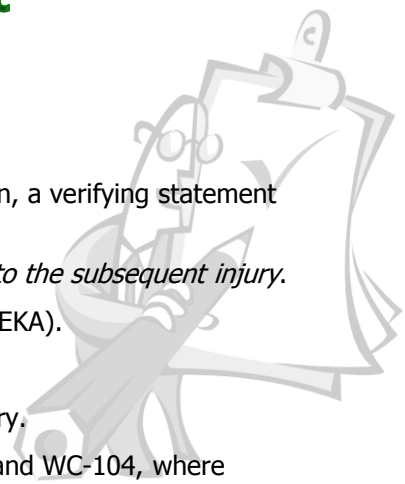
Many times the Fund reconsiders a denial decision when proper documentation is subsequently provided.

A denial decision can be avoided when all requested documentation is submitted to the Fund.

If the employer/insurer fails to file the Form WC-14 with the State Board of Workers' Compensation within 90 days of receipt of the formal denial notice from the Fund, the employer/insurer is barred from recovery on the claim.

Pending Checklist

Pending Checklist



EMPLOYER'S KNOWLEDGE AFFIDAVIT (EKA)

Original notarized Employer's Knowledge Affidavit's S.I.-"H".

1. If verbal knowledge is used or factual statements given, a verifying statement from the employee will expedite evaluation.
2. Legible documents contained in employer's files *prior to the subsequent injury*.
3. Employer's certification letter (SEE REVERSE SIDE OF EKA).

WORKERS' COMPENSATION BOARD FORMS

1. LEGIBLE copy of *front and back* of First Report of Injury.
2. All board forms, including WC-2, WC-3, WC-4, WC-6, and WC-104, where applicable.
3. Current work status: __TO ___TPD ___RTW __WITH __WITHOUT RESTRICTIONS __REG ___LGHT

PRIOR IMPAIRMENT INJURY MEDICAL REPORTS

LEGIBLE medical narratives supporting prior permanent impairment.

SUBSEQUENT INJURY MEDICAL REPORTS

1. LEGIBLE medical narratives supporting subsequent injury. (Up-to-date from Date of Accident).
2. All rehabilitation reports if applicable.
3. Please do not submit reimbursement requests or bills at this time.

MERGER: O.C.G.A 34-9-351(1)

1. Merger requires medical narratives or a statement from the treating physician that clearly establishes merger as defined in Code Section 34-9-351(1).
2. Please keep in mind that the prior impairment must be the *principal factor* that materially, substantially and cumulatively aggravated the (subsequent) condition so as to synergize a greater degree of disability when considered together.

LITIGATION

1. Is there any current or past litigation? ___Yes ___No.
2. Claimant's attorney: NAME, ADDRESS, PHONE.
3. Please briefly describe the nature of the litigation and include all awards as applicable.
4. Are there settlement negotiations in progress? ___Yes ___No. If yes, please advise amount of demand and amount of counter offer.
5. If settled, please submit a copy of the board-approved stipulation.

REIMBURSEMENT

REIMBURSEMENT UNIT

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Bob Fisher
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Marsha Jones
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Nettie Rothstein
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Cynthia Sims
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csims@sitf.ga.gov

Steve Howe
404-656-7083
showe@sitf.ga.gov

- Assigns reimbursement requests to Specialist.
- Reviews reimbursement requests.
- Verifies Reimbursement Agreement on file.
- Verifies Reserve Reduction Certificate on file.
- Verifies required SBWC forms submitted.
- Audits medical, indemnity, and rehabilitation documents and narratives.
- Based upon verified data, authorizes reimbursement of allowable charges.
- Initiates payment process.

RESERVE REDUCTION

In accordance with OCGA 34-9-360(c) "the insurer shall be required to certify that the medical and indemnity reserves have been reduced to the threshold limits of reimbursement."

A third party administrator cannot certify reserves without prior authorization by the insurer. The TPA must provide the Fund with an authorization document and will not be required to submit a Reserve Reduction Letter.

Self-insured employers are not required to certify reduction of reserves.

REQUEST FOR REIMBURSEMENT

1. A completed Reimbursement Request must be returned to the Fund for EACH request.
2. Both indemnity and medical expenses can be included on the form.
3. An itemized list of all medical expenses must accompany the medical Reimbursement Request.
4. A certified counterpart of the Employer or Insurer's computer-generated pay document may be substituted for the itemized list. It must include: payment date, service provider, diagnosis codes, CPT codes, amount paid, and any reductions per fee schedule.
5. Medical narratives and rehabilitation reports must accompany a request for medical expense reimbursement.
6. Funeral benefits, penalty fees, administrative costs, and legal costs are NOT reimbursable by the Fund.
7. No reimbursement will be made unless a Reimbursement Request form is completed and signed by the claiming party.
8. The employer/insurer is required to attest to their efforts to assure that the injured employee is entitled to receive, or to continue to receive workers' compensation benefits. Failure to comply with this regulation may subject the claim to a denial of reimbursement benefits.
9. After the initial fund payment, reimbursement requests may be made in 13-week intervals.

Reimbursement Request

Reimbursement Request

GEORGIA
SUBSEQUENT INJURY TRUST FUND
285 Peachtree Center Avenue, NE
Marquis II Tower, Suite 1250
Atlanta, Georgia 30303

REIMBURSEMENT REQUEST
FORWARD ONLY ONE REQUEST
PER 13 WEEKS OF PAID INCOME OR
MEDICAL BENEFITS
(Submit this form in duplicate)

☐ **Initial Request** ☐ **Intermediate Request** ☐ **Final Request**
(*Please check applicable box*)

_____
Insurer Name (as shown on policy) or Self-Insurer

MAIL CHECK TO:

_____

_____ Employee: _____

_____ Employer: _____

_____
Social Security #

_____
Insurer #

_____
Date of Accident

_____
Compensation Rate

_____
Subsequent Injury #

TOTAL COMPENSATION PAID Attach WC-2, WC-4 & WC 104 forms if not filed with Fund on a prior request	**Date From**	**Date Through**	**Number of Weeks ***	**Amount**
TOTAL DISABILITY				
TEMPORARY PARTIAL Attach list of weekly payments if less than maximum at any time				
PERMANENT PARTIAL _____% Member: _____				
OTHER (Specify: i.e., Death, Settlement, Advance, etc.)				
* compute partial weeks in decimals		TOTAL INDEMNITY TO DATE		
		Weeks	Amount	
Less 104 weeks consisting of: Total Disability Weeks				< >
Temp Partial Weeks				
NET REIMBURSABLE INDEMNITY				
LESS ANY PRIOR INDEMNITY REIMBURSEMENT PAID THROUGH _____ date				< >
TOTAL INDEMNITY REIMBURSEMENT REQUESTED (#_____) weeks				
TOTAL MEDICAL REIMBURSEMENT REQUESTED (See Reverse Instructions)				
TOTAL REIMBURSEMENT REQUESTED				

In compliance with SITF Rule 622-1-.06(1), I hereby certify that the above payments have been made in accordance with the provisions of the Georgia Workers' Compensation Law. I further certify that appropriate investigation has been conducted to assure the accuracy of these payments. (See Reverse Side #IV)

NOTICE: Pursuant to OCGA§ 34-90-360(c) and SITF Rule 622-1-04(2)(a), the undersigned certifies that reserves on this claim have been reduced to the threshold limits of reimbursement. (THIS CERTIFICATION DOES NOT APPLY TO SELF-INSURED EMPLOYERS.)

No reimbursement will be made unless the claiming party signs this form (SITF Rule 622-1-.06(1)(c).

Signed by: _____

Title: _____

Date: _____

THIS SPACE FOR SITF PURPOSES ONLY

Audited on _____

By: _____

Date of adjustment notification _____

Approved for payment _____

If you have a disability and need assistance in completing this form, please contact the Subsequent Injury Trust Fund at (404) 656-7000; TDD (404) 656-7162; FAX (404) 656-7100.

S.I. "C" 2/03

INDEMNITY EXPENSES

Total Disability

A copy of the WC-2 and WC-4 forms must accompany the initial and the final request for indemnity expense reimbursement. The forms must also be submitted annually for the life of the reimbursement claim.

Additionally, if another lost-time/return to work period occurs, please submit a copy of the WC-2 form.

For accidents occurring after July 1, 1992, a copy of the WC-104 must be submitted. This is necessary when the comp rate is expected to be reduced from the TTD to the TPD rate.

Temporary Partial Disability

Attach a list breaking down weekly payments if such payment amounts were less than the maximum allowance under OCGA 34-9-262. (*See examples*)

The Fund reserves the right to request a copy of the actual payment record.

Indemnity Deductible

This deductible is equal to 104 weeks times the comp rate.

Example: Weekly Payments

TOTAL DISABILITY			
FROM	THRU	# WEEKS	AMOUNT
7-28-83	3-04-86	135.8	18,333.00
2-02-87	3-10-88	57.8	7,803.00
5-10-89	5-23-89	2.0	270.00
			$26,406.00

Example: Weekly Payments

TEMPORARY PARTIAL DISABILITY

PAY PERIOD ENDING	PRE INJURY WAGE		POST INJURY WAGE						
2-16-89	288.71	-	188.50	=	100.21	X	.66667	=	66.81
2-23-89	288.71	-	192.00	=	96.71	X	.66667	=	64.47
3-02-89	288.71	-	192.00	=	96.71	X	.66667	=	64.47
3-09-89	288.71	-	192.00	=	96.71	X	.66667	=	64.47
3-16-89	288.71	-	233.76	=	54.95	X	.66667	=	36.63
3-23-89	288.71	-	260.00	=	28.71	X	.66667	=	19.41
3-30-89	288.71	-	192.00	=	96.71	X	.66667	=	64.47
4-06-89	288.71	-	192.00	=	96.71	X	.66667	=	64.47
									$444.93

MEDICAL EXPENSES

$7,500 Deductible

The first $5,000 in allowable expenses is not reimbursable.

Amounts over $5,000 (up to $10,000) will be reimbursed at 50%.

EXAMPLE:

Expenses	$7,000
Less Deductible	5,000
	$2,000
	x 50%
Reimbursed Amount	$1,000

Allowable charges incurred after the $7,500 medical threshold limit is reached are reimbursed at 100%.

-- - No New Deductibles - - -

When the employee returns to work with the same employer and no break in service. *(See Page 21)*

SETTLEMENT

- Assigns Specialist to claims where settlement authority is requested.
- Evaluates settlement demand amount and conditions.
- Reviews disability award.
- Calculates value of lifetime claims.
- Negotiate settlement amounts and conditions.
- Attends WCB mediation hearings.
- Based on verified data, recommends authority or denial of settlement claims.

SETTLEMENT UNIT

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REQUIREMENTS

Agreements

The employer/insurer shall obtain the approval of the Fund on all settlements entered into with the injured worker.

After the Reimbursement Agreement is approved by the State Board of Workers' Compensation, the employer/insurer shall keep the Fund informed of any settlement discussion with the injured worker.

Demand

Prior to reaching a settlement agreement with the employee, the employer/insurer must submit a settlement demand in writing to the Fund. The employer/insurer must keep the Fund apprised of progress and changes in settlement negotiations.

Mediation

Mediation is NOT a requirement to obtain settlement authority. The Fund encourages efforts to extend settlement authority prior to the mediation date in hopes of reaching an agreement.

For cases that must go to mediation, the Fund must have a complete document package no later than 21 days prior to the mediation date.

GRANTING AUTHORITY

1. The Fund will grant settlement authority to the employer/insurer based on investigations by the Workers' Compensation Specialists in the Settlement unit. Usually, this process takes approximately four to six weeks.
2. The Fund does not negotiate settlement with the attorney for the injured worker.
3. Settlement will not be reimbursed if the injured worker returns to work.
4. In the instance where a claim is settled prior to acceptance by the Fund, the Fund is not bound by those settlement terms.
5. Any settlement advances are deducted from the settlement authority granted by the Fund.
6. The Fund should be notified within 30 days of negotiations; sooner on capped claims. Authority granted is only good for 30 days because benefits decrease weekly.
7. Once settlement is agreed upon between the employer/insurer and the injured worker, the Fund should be included as a party of interest. A draft Stipulation Agreement can be faxed to the Fund for review prior to signature by all parties.
8. If an agreement cannot be reached, notify the Fund and the authority request will be returned. The settlement portion of the claim will be closed. Reimbursement will continue as agreed between the Fund and the employer/insurer.

DELAYS

1. Employer/insurer does not provide a settlement recommendation.
2. No demand from the injured worker's attorney.
3. No recent reimbursement request is on file and no updated medical narratives are received.
4. Maximum medical improvement is not reached.
5. Confirmation of SSDI is not received. Applicable for injuries occurring after 7/1/92.
6. Confirmation of current work status.
7. Confirmation of permanent partial disability.

SITF CLAIM ACCEPTANCE

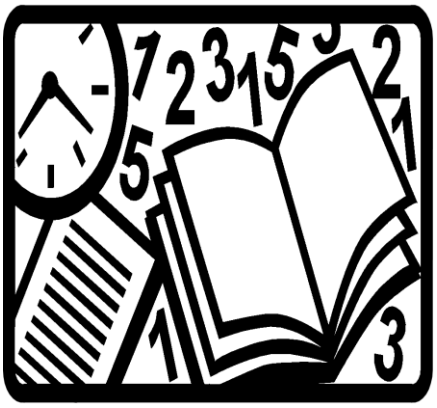
Settlement Prior to Acceptance

When the Fund is not a party to the settlement, it is not bound to the terms of the settlement agreement; however, the fund will review the claim.

Any stipulated settlement agreement must be a "liability" agreement.

Any "no liability" settlement agreement will result in a denial, as the Fund can only reimburse indemnity, medical, and rehabilitation expenses the employer/insurer is legally obligated to pay to the injured worker.

(OCGA 34-9-360)



Settlement After Acceptance

The Fund must be apprised of settlement negotiations and approve the settlement agreement.

Without the Fund's approval, the reimbursement agreement between the Fund and the Employer/Insurer becomes null and void.

Settlement Checklist

Settlement Checklist

Employer/Insurer's
Subsequent Injury Trust Fund
Settlement Authority Request Checklist

DEMAND & EVALUATION

1. Employer/Insurer's settlement evaluation.
2. Demand from the claimant and his/her attorney, if represented.
3. Are there settlement negotiations already in progress? ___yes ___no
4. If yes, please provide amount of demand and counter offer, including provision for open medical expenses.
5. Is a Medicare set-aside provision being considered? ___yes ___no

WORKERS' COMPENSATION BOARD FORMS

1. Board forms, including WC-2, WC-3, WC-4, WC-104, WC-243, WC-240, where applicable.
2. Board awards and advances, if any.
3. Current work status: ___TD ___TPD ___RTW ___WITH ___WITHOUT RESTRICTIONS ___REGULAR ___LIGHT
4. If released to light duty, is there a job available?
5. Have you filed a WC-104 with the Board?

SUBSEQUENT INJURY MEDICAL REPORTS

1. Legible medical narratives for the past 12 months or from the last reimbursement request.
2. Does the injury qualify for a permanent impairment rating? If so, please submit copy.
3. Recent surveillance reports, if any.
4. Rehabilitation reports, if applicable.
5. Copy of Social Security Disability Award, if applicable for claims with accident dates after 7/1/92.
6. Is the case catastrophic or has the employee filed for this designation with the State Board?

LITIGATION

1. Is there any pending litigation? ___yes ___no
2. If yes, please submit copy of WC-14 and describe the nature of the litigation.

TOTALS PAID TO DATE

1. Indemnity $_____
2. Medical $_____

SITF cannot grant settlement authority unless all of the above information and materials are in our possession.

If settlement mediation is imminent, the complete package must reach SIT at least 21 days prior to mediation date.

VISIT OUR OFFICE

Marquis Two Tower, Suite 1250, 285 Peachtree Center Avenue NE, Atlanta, GA 30303
Main Tel: (404) 656-7000

Interstate 75 /85- exit at Courtland Street.
Public garage parking is available at Courtland and Harris Street.

A walkway to the Tower is available at Courtland Street Garage – 7th Floor.

From Downtown Atlanta*:*
I-75/85 North. Exit at Andrew International Blvd.
Turn left on International, cross Piedmont Road, turn right on Peachtree Center Ave.
Public parking is available at Peachtree Center Ave and Harris Street(LAZ Parking).
Public parking is also available at the Courtland Garage.
The Marquis Two Tower is on the corner of Peachtree Center Ave and Baker Street.