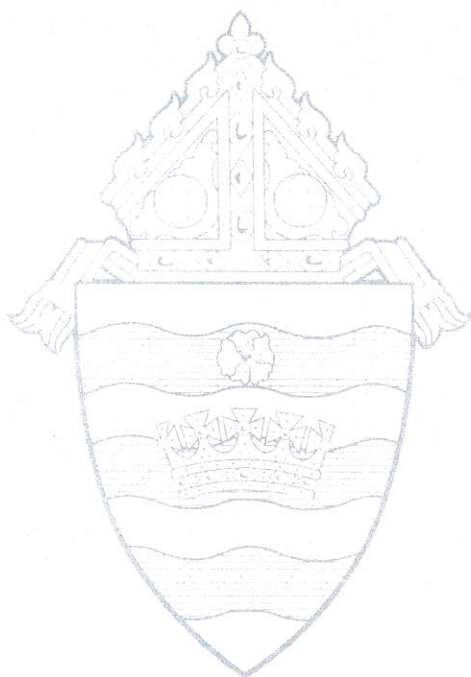


THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA



***Workers' Compensation
Procedures and Guidelines***

WORKERS' COMPENSATION PROCEDURES AND GUIDELINES

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Contact Information:

Fay L. Duhe'
Senior Benefits Specialist
Archdiocese of Atlanta
2401 Lake Park Drive S.E.
Smyrna, GA 30080-8862
404-920-7484
404-920-7481 FAX
fduhe@archatl.com

Lily Gallagher
Benefits Manager
Archdiocese of Atlanta
2401 Lake Park Drive S.E.
Smyrna, GA 30080-8862
404-920-7485
404-920-7481 FAX
lgallagher@archatl.com

Lisa M. Marshall
Senior Claims Adjustor
Planned Administrators, Inc.
Post Office Box 100159
Columbia, SC 29202
1-800-827-5794 ext. 46789
803-870-8542 FAX
Lisa.Marshall@companiontpa.com

Memo

Date: October 8, 2021
To: Business Managers
From: Fay L. Duhe', Senior Benefits Specialist
Re: Workers' Compensation Procedures and Guidelines (rev October 2021))

UPDATED PROCEDURES AND GUIDELINES: Attached are the updated Procedures and Guidelines. *Please review these Guidelines and keep a copy within easy access in the event that an injury occurs at your location.* These Guidelines provide the proper steps to be taken to provide prompt medical attention to the injured party and to ensure that the Archdiocese is in compliance with State regulations.

UPDATED WC-1: Attached is the updated WC-1 First Report of Injury form. (Rev 07/2021) *Please begin using this form immediately.* The WC-1 and all doctor notes, etc. should be sent directly to Fay Duhe': scan, fax or USPS. *Do not send anything to Lisa Marshall unless specifically requested to do so.*

ADJUSTOR: Lisa M. Marshall is the Senior Claims Adjustor, Planned Administrators, Inc. assigned to our account. Lisa's contact information is:

Email: LISA.MARSHALL@companiontpa.com
Phone: 1-800-827-5794 x46789

Board Forms: The revision date on your current forms should be:

WC-P1	Panel of Physicians	Revision 07/2021
•	<i>Fay Duhe' is responsible for selecting physicians for your panel.</i>	
WC-1	Employer's First Report of Injury	Revision 07/2021
WC-BOR	Bill of Rights	Revision 07/2019
WC-6	Wage Statement	Revision 12//2018
•	<i>Fay Duhe' is responsible for completing the WC-6</i>	

UPDATE YOUR PANELS: Please verify the insurance company name, address and phone number listed on ALL of the Panel of Physicians that you currently have posted. Contact Fay if the information is not current. *Failure to update the Panels may result in fines and penalties from the Georgia State Board of Workers Compensation.*

Planned Administrators, Inc.

	Name	
Post Office Box 100159		
Columbia, South Carolina 29202		1-800-827-5794
Address		phone

If you have questions or need further assistance, please contact:

Fay L. Duhe'
Senior Benefits Specialist
Archdiocese of Atlanta
(404) 920-7484
(404) 920-7481 FAX
fduhe@archatl.com

Lily Gallagher
Benefits Manager
Archdiocese of Atlanta
(404) 920-7485
(404) 920-7481
lgallagher@archatl.com

WORKERS' COMPENSATION
PROCEDURES AND GUIDELINES

1. Designate one person at your site as the contact for all workers compensation claims. The supervisor should be the first point of contact for the injured party.
2. The designated person must ensure that the Posted Panel of Physicians and Employee's Bill of Rights are posted in at least one prominent place on the work premises(i.e. near time clock, break room etc.) The Panel of Physicians must be accessible to all employees at all times.
3. Supervisors should notify the designated person immediately of an on-the-job injury, requiring medical attention. Supervisors or the designated person should ensure the injured employee selects a physician from Posted Panel of Physicians at the work location.
4. All injuries or incidents must be reported on a valid WC-1 (First Report of Injury) within 24 hours of the injury. **Only complete Section A.** Please type or print legible. (The State Board of Workers Compensation is now scanning the forms and will assess fines for filing of out-of-date forms.) * Keep a copy for your files.
5. The injured party should NOT complete the WC-1. The designated person or supervisor should complete the form.
6. Fax or scan/email the WC-1, along with a copy of the Panel of Physicians that was posted at the time the injury occurred, to Fay Duhe', Senior Benefits Specialist for the Archdiocese of Atlanta (fduhe@archatl.com 404-920-7481 FAX). If you are unable to reach Fay you may contact Lily Gallagher, Benefits Manager (lgallagher@archatl.com).
7. Determine if there was any indication of horseplay or malfunctioning equipment. If in doubt, contact Fay Duhe '. If you are unable to reach Fay you may contact Lily Gallagher.
8. Statements from witnesses, supervisors, medical reports and any other information you might have regarding the injury should be fax or scan/emailed to Fay Duhe'.
9. If you feel that you have important information regarding the alleged claim, please attach a written statement or call Fay Duhe'.
10. Always take notes on your conversation with the injured party and witnesses. You might be subpoenaed to court or a deposition and this information will be critical.
11. All death cases and in-patient hospitalizations **MUST** be reported IMMEDIATELY – not within 24 hours as designated in #3 above.

12. If the injury requires emergency treatment, send the injured party to the Emergency Room. If the injured party cannot drive, call an ambulance. After the emergency is over, any further treatment will be provided by a physician selected by the employee from the Posted Panel of Physicians.
13. Contact the injured employee and request a copy of the Return to Work Status Form or Discharge papers from Emergency Room. If an employee's ability to work is restricted due to a work-related injury, contact Fay Duhe'.
14. ALWAYS allow the employee to select a physician from your posted panel, and explain the panel to the employee. NEVER suggest or tell the employee that they must see a specific physician.
15. Call the provider that the injured party selected to confirm that the office is still open and accepting Worker's Compensation. If not, immediately call Fay Duhe' to get a replacement physician for the panel. You should use the Authorization Form to provide the billing information for the worker's compensation claim to the provider.
16. Forward all medical documentation, doctor notes, etc. to Fay Duhe'.
17. The injured party will only receive workers compensation benefits if the claim is accepted. This will be determined through investigation of the claim within 21 days of the date of injury. *THIS IS WHY IT IS IMPERATIVE THAT THE FIRST REPORT BE FILED WITHIN 24 HOURS.
18. The injured party will NEVER be paid for being out of work unless the authorized treating physician has taken them out of work.
19. The claimant, if it is a compensable claim, will be paid two thirds of the gross pay. We will be required to complete Form WC-6, listing gross pay for the 13 weeks PRIOR to the date of injury.
20. If the claimant is back at work, part time, and not being paid their normal wages, compensation will again pick up two thirds.
21. If the injured party retains an attorney, NEVER discuss the claim with them or anyone other than Lily Gallagher and Lisa M. Marshall, unless authorized by either of them.
22. When in doubt, contact Fay Duhe' or Lily Gallagher.

Workers' Compensation - **Job Classified Code No.**

Class codes are assigned to differentiate between the various job duties or scope of work performed by employees. These codes are assigned when reporting a work-related injury, **Form WC-1**.

Below is the list of Workers' Compensation codes currently use by Archdiocese of Atlanta

8868	All Clergy, All Sisters, All Teachers, All Office and Administrative Personnel, Managers, Speakers, Coordinators, Religious Education, Musicians and Paid Choir Members
9101	Janitors, Maintenance Personnel, Yard Men, Dishwashers
0913	Maids and/or Housekeepers, Rectory Cooks, Cafeteria Cooks & Help, Cleaning Companies WITHOUT Workmen's Compensation Coverage
8829	Nurses (RN, LPM)
7383	Bus Drivers

THE ROMAN CATHOLIC
ARCHDIOCESE OF ATLANTA



Authorization Form

Date: _____

Treating Facility/Hospital: _____

To: _____

Fax: _____

Phone: _____

Employee Name: _____ DOB: _____

Body Part Affected _____

Work Location: _____

CLAIMS OFFICE:

**Planned Administrators, Inc.
Post Office Box 100159
Columbia, South Carolina 29202**

Direct: 1-800-827-5794, ext. 46789

Fax: 1-803-870-8542

Lisa Marshall, Senior Claims Adjustor

EMPLOYER:

Fay Duhe'
Senior Benefits Specialist
Archdiocese of Atlanta
2401 Lake Park Drive SE
Smyrna, GA 30080

(404)920-7484 (Direct Line)
(404) 920-7481 (Fax)
fduhe@archatl.com

Lily Gallagher
Benefits Manager
Archdiocese of Atlanta
2401 Lake Park Drive SE
Smyrna, GA 30080

(404) 920-7485 (Direct Line)
(404) 920-7481 (Fax)
lgallagher@archatl.com

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.	Date of Injury
A. IDENTIFYING INFORMATION							
EMPLOYEE	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Phone Number		Employee E-mail		
Mailing Address				City	State	Zip Code	
EMPLOYER	Name RCAA Administrative SVCS		NAICS Code 813110	Nature of Business (Trade, Transport, Mfg., etc.)			
Mailing Address 2401 Lake Park Drive, SE			Phone Number 404-920-7485	Employer FEIN 83-35444215			
City Smyrna	State GA	Zip Code 30080-8862	Employer E-mail lgallagher@archatl.com				
INSURER / SELF-INSURER	Name RCAA Administrative SVCS		Insurer/Self-Insurer FEIN 83-35444215	Insurer/ Self-Insurer File #			
CLAIMS OFFICE	Name Planned Administrators Inc.		Claims Office FEIN # 57-0718839	Claims Office Phone 800-827-5794	Claims Office E-mail Lisa.Marshall@companiongroup.com		
SBWC ID# (five digit no.) 20621	Mailing Address P O Box 100159		City Columbia	State SC	Zip Code 29202		
EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week		Wage rate at time of Injury or Disease: <input type="checkbox"/> per Hour <input type="checkbox"/> per Day <input type="checkbox"/> per Week <input type="checkbox"/> per Month		
Insurer Type Code <input type="checkbox"/> I - Insurer <input checked="" type="checkbox"/> S-Self-insurer <input type="checkbox"/> Group Fund		List Normally Scheduled Days Off					
INJURY/ILLNESS & MEDICAL	Time of Injury <input type="checkbox"/> am <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did Injury/Illness Occur on Employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Injury/Illness		Body Part Affected			
How Injury or Illness / Abnormal Health Condition Occurred							
Treating Physician (Name and Address)		Initial Treatment Given: <input type="checkbox"/> None <input type="checkbox"/> Minor: By Employer <input type="checkbox"/> Minor: Clinical/Hospital <input type="checkbox"/> Emergency Room <input type="checkbox"/> 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	
<input type="checkbox"/> B. INCOME BENEFITS Form WC-6 must be filed if weekly benefit is less than maximum							
Previously Medical Only <input type="checkbox"/> Yes <input type="checkbox"/> 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:							
<input type="checkbox"/> Temporary total disability <input type="checkbox"/> Temporary partial disability <input type="checkbox"/> 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.							
<input type="checkbox"/> C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION							
Benefits will not be paid because:							
<input type="checkbox"/> 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.sbcw.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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. 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. If you need additional help, call your insurance company or self-insurer claims office.
3. 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.

B. NOTICE TO INSURER / SELF-INSURER

Upon receipt of this form, check to see that it is complete and accurate. Be sure to list the correct insurance company and their SBWC ID number.

Complete Section B, C, or D and file with the Board and send a copy of both sides of the Form to the employee and all counsel of record within 21 days of the employer's knowledge of disability, injury, or death.

Section B is completed when indemnity benefits are paid or due, including salary in lieu.

Section C is completed when claim is controverted in full or in part.

Section D is completed when no indemnity benefits are due and/or have NOT been controverted.

Form WC-6 must be filed if weekly benefits are less than the maximum.

C. NOTICE TO EMPLOYEE

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: 1-800-533-0682

Atlanta: (404) 656-3818

<https://sbwc.georgia.gov>

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).

(This notice must be posted in a conspicuous place readily accessible to the employee at all times.)

PANEL OF PHYSICIANS

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 (see O.C.G.A. § 34-9-80).

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 six physicians, including an orthopedic surgeon with no more than two physicians from industrial clinics (see O.C.G.A. § 34-9-201). Further, this panel shall include one minority physician, whenever feasible (see Rule 201 for definition of minority physician). 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 to another 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 30303-1399
404-656-3818
or 1-800-533-0682
<https://sbwc.georgia.gov>

Selecting Doctors for your Panel

- Fay Duhe' is responsible for selecting doctor for your panel.
- We select doctors we feel will give the best medical care.
- We select doctors as close as possible (within 50 miles of the job site).

This form is completed by Fay Duhe'

name _____ phone _____ name/address/phone _____

name/address/phone _____ phone _____

(Address _____)

The insurance _____ under the _____

_____ Name _____

_____ address _____ phone _____

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <https://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).

WC-BILL OF RIGHTS

GEORGIA 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 Workers' 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 Workers' 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 six doctors or the name of the certified WC/MCO that provides medical care, 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. All injuries occurring on or before June 30, 2013 shall be entitled to lifetime medical benefits. If your accident occurred on or after July 1, 2013 medical treatment shall be limited to a maximum of 400 weeks from the accident date. If your injury is catastrophic in nature you may be entitled to lifetime medical benefits.
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 \$675 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) 656-0849.
6. In all other cases (non-catastrophic), you are entitled to receive two-thirds of your average weekly wage but not more than \$675 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 \$450 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 \$450 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 \$675 per week. A widowed spouse with no children will be paid a maximum of \$270,000. 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. An employee has a continuing obligation to cooperate with medical providers in the course of their treatment for work related injuries. 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.
9. If your dependent(s) do not receive allowable benefit payments, the dependent(s) must file a claim with the State Board of Workers' Compensation within one year after your death or lose the right to these benefits.
10. Any request for reimbursement to you for mileage or other expenses related to medical care must be submitted to the insurance carrier/employer within one year of the date the expense was incurred.
11. If an employee unjustifiably refuses to submit to a drug test following an on-the-job injury, there shall be a presumption that the accident and injury were caused by alcohol or drugs. If the presumption is not overcome by other evidence, any claim for workers' compensation benefits would be denied.
12. You shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not more than \$10,000.00 or imprisonment, up to 12 months, or both, for making false or misleading statements when claiming benefits. Also, any false statements or false evidence given under oath during the course of any administrative or appellate division hearing is perjury.

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 or visit our website: <http://www.sbcw.georgia.gov>. 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.

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.sbcw.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).

(Este aviso debe ser puesto en un lugar accesible al empleado todo el tiempo.)

PANEL DE DOCTORES

AVISO OFICIAL

Esta compañía opera bajo las Leyes de Compensación de Trabajadores de Georgia

LOS TRABAJADORES DEBEN REPORTAR TODOS LOS ACCIDENTES INMEDIATAMENTE AL EMPLEADOR Y AVISAR AL EMPLEADOR PERSONALMENTE, UN AGENTE, PREPRESENTANTE, PATRON, SUPERVISOR O CAPATAZ.

Si un trabajador es lesionado en el trabajo el empleador debe pagar gastos médicos y rehabilitación dentro de los límites de la ley. En algunos casos el empleador también pagará una parte de los salarios perdidos de los empleados.

Lesiones de trabajo y enfermedades ocupacionales deben ser reportados por escrito cuando sea posible. El trabajador puede perder el derecho a recibir compensación si un accidente no es reportado dentro de 30 días (referencia O.C.G.A. § 34-9-80).

El empleador ofrecerá sin costo alguno, si es pedido, un formulario para reportar accidentes y también debe suministrar, sin costo alguno, información acerca de compensación de trabajadores. El empleador también debe suministrar al empleado, cuando sea pedido, copias de formularios de la Junta archivados con el empleador pertenecientes a reclamos de los empleados.

Un trabajador lesionado en el trabajo debe seleccionar un doctor de la lista abajo. El panel mínimo debe consistir de por lo menos seis médicos, incluyendo un cirujano ortopédico con no más de dos médicos de clínicas industriales (referencia O.C.G.A. § 34-9-201). Además, este panel debe incluir un médico minoritario, cuando sea posible (vea la regla 201 de definición de médicos minoritarios.) La Junta puede otorgar excepciones al tamaño requerido del panel donde se demuestre que más de cuatro médicos no son razonablemente accesibles. Un cambio de un doctor a otro en la lista se puede hacer fin permiso. Cambios adicionales requieren el permiso del empleador o de la Junta Estatal de Compensación de Trabajadores.

Junta Estatal de Compensación de Trabajadores
270 Peachtree Street, N.W.
Atlanta, Georgia 30303-1299
404-656-3818
o 1-800-533-0682
<https://sbwc.georgia.gov>

_____ nombre /dirección /teléfono _____ nombre /dirección /teléfono

_____ nombre /dirección /teléfono _____ /dirección /teléfono

(Médicos adicionales)

La compañía de seguro que provee cobertura es:

_____ Nombre _____

_____ dirección _____

Selecting Doctors for your Panel

- Fay Duhe' is responsible for selecting doctor for your panel.
- We select doctors we feel will give the best medical care.
- We select doctors as close as possible (within 50 miles of the job site).

This form is completed by Fay Duhe'

SI USTED TIENE PREGUNTAS LLAME AL (404) 656-3818 o 1-800-533-0682 o VISITA sbwc.georgia.gov
HACER FALSOS TESTIMONIOS VOLUNTARIAMENTE CON EL PROPÓSITO DE OBTENER O NEGAR BENEFICIOS ES UN CRIMEN SUJETO A PENALIZACIÓN POR VIOLACIÓN (O.C.G.A. §34-9-18 Y §34-9-19.)

JUNTA ESTATAL DE COMPENSACIÓN DE TRABAJADORES DE GEORGIA

DECLARACIÓN DE DERECHOS PARA EL TRABAJADOR LESIONADO

Según lo requiere la Ley O.C.G.A. §34-9-81.1, esto es un recuento de sus derechos y responsabilidades. La Ley de Compensación de Trabajadores le provee a usted, como trabajador en el Estado de Georgia, ciertos derechos y responsabilidades si usted se lesiona en el trabajo. La Ley de Compensación de Trabajador lo provee a usted con cobertura de lesiones relacionadas con el trabajo aunque su lesión sea en el primer día de trabajo. Además de sus derechos, usted también tiene ciertas responsabilidades. Sus derechos y responsabilidades están descritos abajo.

Derechos de los Empleados

1. Si usted se lesiona en el trabajo, usted puede recibir rehabilitación médica y beneficios de ingresos. Estos beneficios son proveídos para ayudarlo a regresar al trabajo. También sus dependientes pueden recibir beneficios si usted muere como resultado de lesiones recibidas en el trabajo.
2. Se le requiere a su empleador que anuncie una lista de seis doctores o por lo menos el nombre de un WC/ MCO certificado que provee cuidados médicos, al menos que la Junta halla otorgado una excepción. Usted puede escoger un doctor de la lista sin el permiso de su empleador. Sin embargo, en una emergencia, usted puede recibir asistencia medica temporaria de cualquier otro medico hasta que la emergencia termine después usted debe recibir tratamiento de los médicos que se anuncian en la lista.
3. Sus cuentas médicas autorizadas, cuentas de hospital, rehabilitación en algunos casos, terapia física, recetas y gastos de transporte serán pagados si la lesión fue ocasionada por un accidente en el trabajo. Todas las lesiones que ocurren en o antes 30 de junio de 2013 se tendrá derecho a beneficios médicos de por vida. Si el accidente ocurrió en o 1 de julio del 2013 el tratamiento médico será limitado a un máximo de 400 semanas a partir de la fecha del accidente. Si su lesión es catastrófica en la naturaleza que puede tener derecho a beneficios médicos de por vida.
4. Usted tiene derecho a recibir beneficios de ingresos semanales si usted ha perdido tiempo por más de siete días debido a una lesión. Su primer cheque debe ser enviado a usted dentro de 21 días, después del primer día que faltó al trabajo. Si esta fuera más de 21 días consecutivos debido a su lesión, se le pagara la primera semana.
5. Los accidentes son clasificados ya sea catastróficos o no catastróficos. Lesiones catastróficas son las que envuelven amputación, parálisis severas, lesiones severas de la cabeza, quemaduras severas, ceguera que prevenga al empleado a que pueda realizar el o ella su trabajo anterior o cualquier otro trabajo disponible en numero considerable dentro de la economía nacional. En casos catastróficos usted tiene derecho a recibir un promedio de dos terceras partes de su ingreso semanal pero no más de \$675 por semana por una lesión relacionada con el trabajo durante todo el tiempo que usted no pueda regresar a su trabajo. Usted también tiene derecho a recibir beneficios médicos y de rehabilitación. Si usted necesita ayuda en esta área llame a la Junta Estatal de Compensación de Trabajadores al (404) 656-0849.
6. En todos los otros casos (no catastróficos) usted tiene el derecho a recibir dos terceras partes de su sueldo promedio semanal pero no más de \$675 por semana de una lesión relacionada de trabajo, usted recibirá estos beneficios mientras usted este incapacitado. Pero no más de 400 semanas si no esta trabajando y se determina que usted esta capacitado a desempeñar con restricción por 52 semanas consecutivas o 78 semanas agregadas sus ingresos semanales serán reducidos a dos terceras partes de su sueldo promedio pero no más de \$450 por semana, que no excedan 350 semanas.
7. Cuando usted pueda regresar a trabajar pero solo pueda conseguir empleo de salario bajo como resultado de su lesión usted tiene derecho a un beneficio semanal de no más de \$450 por semana pero no más de 350 semanas.
8. En caso de que usted muera como resultado de un accidente en el trabajo, su dependiente (s) recibirán para gastos de entierro \$7,500 y dos terceras partes de su sueldo promedio semanal, pero no más de \$675 por semana. Una esposa viuda sin niños se le pagara un máximo de \$270,000 en beneficios continuos hasta que EL/ELLA se vuelva a casar o abiertamente cohabite con una persona del sexo opuesto.
9. Si usted no recibe beneficios cuando sea debido, la compañía de seguro/empleador debe de pagar penalidades, que se agregaran a sus pagos.

La Junta de Compensación de Trabajadores le proporcionará la información relativa a la manera de presentar una reclamación y responderá a cualquier preguntas adicionales sobre sus derechos en virtud de la ley. Si usted llama en la zona de Atlanta, el teléfono es el (404) 656-3818 y fuera de la zona metropolitana de Atlanta, llame al 1-800-533-0682, o escriba a la Junta Estatal de Compensación de Trabajadores a 270 Peachtree Street, NW, Atlanta, Georgia 30303-1299 o visita sitio web: <http://www.sbcw.georgia.gov>. No es necesario tener un abogado para presentar una reclamación a la Junta; sin embargo, si usted cree que necesita los servicios de un abogado y no tiene uno propio, usted puede ponerse en contacto con el Servicio de Referencia de Abogados (Lawyers Referral Service) al teléfono (404) 521-0777 o al 1-800-237-2629.

Responsabilidades de los Empleados

1. Usted debe de seguir las reglas escritas de seguridad y otras pólizas razonables y procedimientos del empleador.
2. Usted debe reportar cualquier accidente inmediatamente, pero no más tarde de 30 días después del accidente, a su empleador, los representantes del empleador, su capataz o supervisor inmediato. Fallar en hacerlo puede resultar en la pérdida de sus beneficios.
3. Un empleado tiene la continua obligación de cooperar con proveedores médicos en el curso de su tratamiento relacionado con lesiones de trabajo. Usted debe aceptar tratamientos médicos razonables y servicios de rehabilitación cuando sean ordenados por la Junta Estatal de Compensación de Trabajadores o la Junta puede suspender sus beneficios.
4. No se permitirá compensación por una lesión o muerte debido a una conducta mal intencionada de los empleados.
5. Debe de notificar a la compañía de seguro/empleador de su dirección cuando se mude a un nuevo lugar. Usted debe notificar a la compañía de seguros/empleador cuando usted halla regresado a trabajar de tiempo completo o medio tiempo y reportar la cantidad de su salario semanal porque usted puede tener derecho a algún beneficio de ingreso aun así halla regresado al trabajo.
6. Una esposa dependiente de un empleado difunto debe notificar a la compañía de seguro/ empleador de cambios de dirección o nuevo matrimonio.
7. Usted debe intentar un trabajo aprobado por su medico autorizado aunque el pago sea mas bajo que en el trabajo que usted tenia cuando se lesionó, si usted no intenta el trabajo sus beneficios pueden ser suspendidos.
8. Si usted cree que debe recibir beneficios y su compañía de seguros/empleador niega estos beneficios. Usted debe de hacer un reclamo dentro de un año después del ultimo tratamiento medico o dentro de dos años de su último pago de beneficios semanales o usted perderá sus derechos a estos beneficios.
9. Si su (s) dependiente (s) no reciben beneficio de pagos permitidos. El dependiente debe hacer un reclamo con la Junta Estatal de Compensación de Trabajadores dentro de un año después de su muerte o perderán los derechos a estos beneficios.
10. Algún pedido de reembolso a usted por millas o otros gastos relacionados con tratamiento medico debe ser sometidos a la compañía de seguros/empleador dentro de un año del día que los gastos fueron incurridos.
11. Si un empleado injustificadamente rehúsa a someterse a una prueba de droga después de una lesión en el trabajo habrá una presunción de que el accidente y lesión fueran causados por droga o alcohol. Si la presunción no se sobrepone por otras evidencias, algún reclamo hecho para beneficios de compensación de Trabajador serán negados.
12. Usted será culpable de un delito menor y una vez convicto debe ser castigado con una multa de no más de \$10,000.00 o encarcelamiento de hasta 12 meses o las dos, por hacer declaraciones falsas o engañosos testimonios cuando reclame beneficios. También cualquier declaración falsa o evidencia falsa dadas bajo juramento durante el curso de alguna audiencia de división de apelación o administración es perjurio.

GEORGIA STATE BOARD OF WORKERS' COMPENSATION WAGE STATEMENT

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
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A. IDENTIFYING INFORMATION

EMPLOYEE		Mailing Address		
E-mail Address		City	State	Zip Code
EMPLOYER		Mailing Address		
E-mail Address		City	State	Zip Code
INSURER/ SELF-INSURER		Name		
CLAIMS OFFICE		Mailing Address		
SBWC ID #	Insurer/Self-Insurer File #	City	State	Zip Code

B. COMPUTATION OF AVERAGE WEEKLY WAGE

If the weekly benefit is less than the maximum, complete the schedule below for thirteen (13) weeks immediately preceding the accident. If the employee has not been in your employ for the thirteen (13) weeks, complete this schedule showing gross weekly earnings of a similar employee in the same employment. If either of the foregoing methods cannot be reasonably and fairly applied, the full time weekly wage of the injured employee should be used.

13 Weeks of Employee's Wages
 13 Weeks of a Similar Employee's Wages
 Full Time Weekly Wage of Injured Employee: \$ _____

SCHEDULE OF WEEKLY EARNINGS

Week	From Date MM/DD/YYYY	To Date MM/DD/YYYY	No. of Days Worked	Gross Amount Paid Including Overtime or Extra Work	Value of Additional Compensation					Total Earnings
					Meals	Lodging	Rent	Tips	Other	
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
Total										
Average Weekly Earnings										

C. SCHEDULED DAYS OFF

REQUIRED TO COMPLETE:
 Mon
 Tue
 Wed
 Thur
 Fri
 Sat
 Sun
 No Off Days

D. REMARKS

REMARKS:

Type or Print Name	Signature	Date
E-mail Address		Phone Number

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.sbcw.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).



Date: March 2, 2009, *revised July 1, 2011*

To: Pastors, Principals and Business Managers

From: Charles Thibaudeau, Human Resources Director

Re: **Volunteers and Workers' Compensation**

This memo will serve to clarify claim reporting procedures for injured volunteers.

Volunteers who are filling a job that would normally be filled by a paid employee may be eligible for workers compensation medical benefits. Current policies and procedures should be followed for reporting work-related injuries and completing the WC-1 (First Report of Injury). If you need a copy of the current Policies and Procedures Guidelines or have questions, please contact Lily Gallagher, Benefits Manager, at (404) 920-7485 or at lgallagher@archatl.com.

Volunteers who are NOT filling a job that would normally be filled by a paid employee are eligible for Medical Payments Coverage with a limit of \$5,000.00 with Catholic Mutual Group. This Med-Pay coverage is available regardless of negligence. This coverage is EXCESS to the volunteer's personal medical insurance. If the volunteer does NOT have medical insurance, then this excess coverage becomes primary. Claims should be filed using the Non-Employee Accident Injury Report and faxed to the Catholic Mutual Atlanta Service Office at (404) 920-7376. If you need a copy of the Non-Employee Accident Injury Report or have questions, please contact Alex Hagan, Catholic Mutual Group, at (404) 920-7377 or (404) 920-7375 or by email: ahagan@catholicmutual.org.

Thank you for your cooperation.

Archdiocese of Atlanta

2401 Lake Park Drive, S.E. ■ Smyrna, Georgia 30080-8862
404-920-7800 ■ Fax 404-920-7801 ■ www.archatl.com



Memo

Date: April 16, 2012
To: Pastors, Principals and Business Managers
From: Charles Thibaudeau, Human Resources Director
Re: **Hiring of Off-duty Police Officers and Workers' Compensation**

This memo will serve to provide clarification for the hiring of off-duty police officers.

Off-duty police officers hired for traffic control or security are independent contractors. They must be paid as independent contractors, through A/P, and issued a 1099. Police Officers are only employees of the city county, state or other government agency. We only contract off-duty police officers for their service.

You are not really controlling the police officer's time. You have latitude in giving them a timeframe in which you need their services for traffic control or security. The police officer is given guidelines or instructions as to what is needed and then the officer uses his/her own experience and judgment.

Police officers should not be included on the workers compensation reporting. If an off-duty police officer is injured while providing services, please immediately contact Lily Gallagher, Benefits Manager, at (404) 920-7485 or at lgallagher@archatl.com. The circumstances will be investigated and a determination of coverage will be made at that time.

Archdiocese of Atlanta

2401 Lake Park Drive, S.E. ■ Smyrna, Georgia 30080-8862
404-920-7800 ■ Fax 404-920-7801 ■ www.archatl.com

WORKERS' COMPENSATION
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