Procedure: 4.5.2p5. [III.U.6.e.] Authorized and Contingent Leaves of Absence Without Pay

[Previously Titled: Leave of Absence without Pay]

Revised: January 12, 2016
Last Reviewed: January 12, 2016
Adopted:

I.PURPOSE:

The Commissioner (or his/her designee) or a technical college president (or his/her designee) may grant an eligible employee an authorized (regular) or contingent leave of absence without pay pursuant to the provisions of this procedure and corresponding State Personnel Board Rules.

An employee's placement on a continuous period of leave without pay is usually associated with a medically-related issue/situation in which the projected absence is for a limited time period and the employee is reasonably expected to return to work at the conclusion of the leave.

In all such instances, the TCSG work unit is responsible for paying the employer's portion of associated health insurance costs, whether or not the employee is a current member of the State Health Benefit Plan or whether he/she currently carries health insurance and elects to continue his/her coverage while on a leave of absence without pay.

II. RELATED AUTHORITY:

Employee Benefit Council Rules – Flexible Benefits Program
State Health Benefit Plan Rules and Regulations
State Personnel Board Rule 16
TCSG Procedure 4.1.4p. – Categories of Employment

III. APPLICABILITY:

All work units and technical colleges associated with the Technical College System of Georgia.

IV. DEFINITIONS:

Break-in-Service: a voluntary or involuntary separation from employment for at least one full business day. For purposes of this procedure, an authorized (regular) or contingent leave of absence without pay is not considered a formal break-in-service.

Eligible Employee: an individual appointed to a full- or part-time salaried position in a TCSG work unit and who is eligible for State of Georgia-sponsored benefits as provided in the TCSG procedure governing Categories of Employment.

Immediate Supervisor: a supervisor charged with the responsibility for developing performance plans/ expectations and who coaches, develops, and assesses the performance of subordinate employee(s).

TCSG Work Unit: the TCSG System Office, Quick Start Headquarters, Quick Start Regional Office or training center, or an associated technical college.

V. ATTACHMENTS:

Attachment 4.5.1p.a4. FMLA Certification of Health Care Provider Form for Employee's Serious Health Condition Form
Attachment 4.5.1p.a3.FMLA Certification of Health Care Provider Form for Family Member's Serious Health Condition Form
Attachment 4.5.2p5.a1. – GTLI Continuation While on Leave of Absence without Pay Form
Attachment 4.5.2p5.a2. – Employer's First Report of Injury or Occupational Disease Form (WC1)
Attachment 4.5.2p5.a3. – Notice of Payment or Suspension of Benefits Form (WC2)
Attachment 4.5.2p5.a4. – Request to Continue Health Benefits during Leave of Absence without Pay

VI. PROCEDURE:

A. General Provisions

1.An eligible employee who has exhausted all available paid leave or elects not to use available paid leave to cover a long term absence of more than fifteen (15) calendar days may not be placed on an authorized or contingent leave of absence without pay by a TCSG work unit absent a written request (from the employee) and approval from a designated System Office or technical college official.

NOTE: pursuant to State Accounting Office guidelines, short-term absences without pay which total of which is less than fifteen calendar (15) days should be recorded in *Absence History* with accompanying "salary docks". Examples would be one or more day(s) in a non-pay status initiated in response to a furlough imposed in response to an approved temporary reduction-in-force plan or when an employee is not permitted to return to work after exhausting all available paid leave while awaiting documentation from his/her attending physician or other health care provider/professional.

2. An eligible System Office employee may submit a written request for a leave of absence without pay to the Commissioner or his/her designee for a specified, continuous period of time not to exceed twelve (12) calendar months.

3. A technical college employee may submit a written request for a leave of absence without pay to the technical college president or his/her designee for a specified, continuous period of time not to exceed twelve (12) calendar months.

4. An employee may request either an authorized (regular) leave of absence without pay or a contingent leave of absence without pay.

5. When an employee is eligible for family leave and is absent from work is due to a qualifying reason, he/she should be placed on family leave (with or without pay) prior to placement on a leave of absence without pay.

6. If an employee's family leave entitlement has been exhausted and he/she remains unable to return to work, he/she may then request a leave of absence without pay consistent with the provisions of this procedure.

7. A leave of absence without pay does not result in a break-in-service for employment-related purposes.

B. Authorized (Regular) Leave of Absence Without Pay

1.An authorized leave of absence without pay may not exceed twelve (12) calendar months.

2. If an employee's request for an authorized leave of absence without pay is approved, the position which the employee occupies or a comparable position in terms of title, duties and responsibilities and pay shall be held for the employee's return.

3. At the expiration of an authorized leave of absence without pay, an employee shall be returned to work without loss of any rights provided he/she has complied with all terms and conditions outlined in the notice of approval.

C. Contingent Leave of Absence Without Pay

1.A contingent leave of absence without pay may not initially exceed twelve (12) calendar months.

2. As provided in Paragraph VI.F., an employee may request an extension of an approved leave of absence without pay for an additional period of time, the total of which may not exceed twenty-four (24) calendar months unless otherwise required by state of federal law. Any proposed extension beyond the initial twelve (12) months may only be requested as a contingent leave of absence without pay

3. If an employee's request for a contingent leave of absence without pay is approved, the position which the employee occupies is not held.

4. The TCSG work unit may elect to fill the employee's position at any time during his/her contingent leave of absence.

5. An employee placed on a contingent leave of absence without pay may return to work only if a "suitable vacancy" (as defined in the notice of approval) is available at the expiration of the leave and/or when written notice of his/her intent to return to work is initiated before the period of approved leave has concluded.

D. Request for a Leave of Absence Without Pay

1.As provided in Paragraph VI.A.1., a System Office employee must submit a written request for a leave of absence without pay to the Commissioner or his/her designee.

2. As provided in Paragraph VI.A.2., a technical college employee must submit a written request for a leave of absence without pay to the technical college president or his/her designee.

3. A copy of the written request must be provided to the employee's immediate supervisor and the System Office or technical college Director of Human Resources.

4. A written request must include the following information:

a.the type of leave of absence without pay requested, i.e., authorized (regular) or contingent.
b.the reason for the leave of absence without pay;
c.the length of the leave of absence;
d.the start date and the projected date of return; and,
e.any other information relevant to the request.

5. A request based on an employee illness or disability or the health condition of a family member should be accompanied by a completed Certification of Health Care Provider Form for Serious Health Condition (Attachment 4.5.1p.a3 or Attachment 4.5.1p.a4.) or other documentation from a health care provider/professional supporting the need for a leave of absence.

6. If an employee does not specify in his/her request the type of leave of absence he/she desires, the designated reviewing official should attempt to discuss the request with the employee before he/she determines the type of leave of absence without pay that will be approved and the accompanying terms and conditions.

E. Review Process:

1.A designated official's review and determination of an employee's request of a leave of absence without pay shall include the following considerations:

a.the reason(s) for the proposed leave of absence;
b. the amount of time requested;
c. the employee's documented job performance, behavior, and attendance;
d. the operational needs of the TCSG work unit;
e. the employee's years of State service; and,
f. any previous accommodation efforts by the TCSG work unit.

2. As provided in Paragraph VI.B.3., a leave of absence without pay is generally approved only for medically-related reasons when an employee is reasonably expected to return to work at the conclusion of the leave. Similarly, a leave of absence should be for a short period of time.

3. An employee's request for a leave of absence without pay will not be approved for the following reasons:

a.relocation;
b. incarceration;
c. accepting another job; or,
d. participation in an academic program of study at a college or university which primarily benefits the employee and is not directly related to the employee's current job responsibilities with the System Office or technical college.

4. The designated official's review should be completed in a timely manner and the approval or denial must be communicated to the employee in writing.

5. The written notification for an approved authorized or contingent leave of absence without pay shall specify the following terms and conditions:

a.whether the leave of absence is designated as authorized (regular) or contingent;
b. the beginning date and end date;

c. the date whereby written notice must be provided to the named official(s) of the employee's intent to return to work at the expiration of the leave of absence (e.g., no later than ten [10] calendar days prior to the expiration of the leave); and,
d. when applicable, the date a return-to-work statement signed by the employee's treating health care provider/professional must be submitted. Additionally, the statement must indicate whether the employee can return to work and perform the essential functions of his/her job with or without reasonable accommodation(s). If reasonable accommodation(s) are recommended, the written statement must outline the specific accommodation(s) needed.

6. If an authorized (regular) leave of absence without pay is approved, the written notification must also identify the location and job/position which will be available upon an employee's return to work.

7. If a contingent leave of absence without pay is approved, the written notification must define the term "suitable" vacancy to include the specific job title, the organizational work unit location where the position resides, as well as the requirement that the position be vacant, properly budgeted, and otherwise available for the employee.

8. if an employee's request for an authorized (regular) leave of absence without pay will not be approved, the designated reviewing official must notify the employee, in writing of his/her decision and, when circumstances dictate, offer the employee an opportunity to request a contingent leave without pay.

F. Extension of an Authorized or Contingent Leave of Absence Without Pay

1. An employee may initiate a written request for an extension of his/her approved leave of absence without pay beyond the initial approval period or the established twelve (12) months maximum consistent with the provision of this paragraph.

2. An extension will be considered only in response to an employee's or his/her family member's serious health condition provided there is a reasonable expectation that he/she will be able to return to work at the conclusion of the continued leave of absence.

3 The written request must be for a contingent leave of absence without pay must include the following:
a.the number of calendar months requested (not to exceed a total of twenty-four consecutive calendar months); and,
b. documentation from the treating health care provider/professional supporting the need for a continued leave of absence;

4. The designated System Office or technical college official should, after his/her review, approve or deny the request in writing and if approved specify the accompanying terms and conditions consistent with the provisions of Paragraph VI.E.

5, An approval notice should also include a statement that this action does not extend the time period an employee is eligible to continue his/her health insurance coverage under State Health Benefit Plan (SHBP) or flexible benefits insurance options as administered under the Flexible Benefits Program (i.e., twelve (12) calendar months). NOTE: the SHBP will provide the employee with information regarding his/her ability to continue health insurance coverage beyond this period through COBRA.

G. Continuation of Benefits:

1.An eligible employee on an authorized or contingent leave of absence without pay may maintain his/her health insurance (through the State Health Benefit Plan) and continue his/her flexible benefits insurance benefit options (through the Flexible Benefits Program) as well as his/her health care spending account contributions.

2.An employee shall be advised of the cost of maintaining health insurance and flexible benefits insurance options, the process for making premium payments, the consequences for not making required payments in a timely manner, the impact of Open Enrollment on benefit elections during an unpaid leave of absence without pay and, as applicable, the actions that will be taken when an employee returns to work from an unpaid leave of absence without pay during the current SHBP or Flexible Benefits Plan Year or when a return crosses Plan Years if premium payments have not been continued.

3.Group Term Life Insurance (GTLI) Under the Employees' Retirement System of Georgia

a.an employee who is a member of the Employees' Retirement System of Georgia (ERS) with one or more years of creditable service in the Old or New Plan may maintain group term life insurance coverage while on an approved leave of absence without pay.
b.a request to continue coverage must be made in writing to ERS prior to beginning the leave of absence using Attachment 4.5.2p5.a1. (Group Term Life Insurance Continuation While on Leave Without Pay Form). GTLI coverage will terminate if a written request is not filed with ERS in a timely manner.

NOTE: ERS members of the Georgia State Employees' Pension and Savings Plan (GSEPS) are not provided group term life insurance coverage.

4. State Health Benefit Plan Coverage

a.as provided in Paragraph VI.G.1. an active employee who is an enrolled member of the State Health Benefit Plan (SHBP) may continue his/her SHBP coverage during the approved period of an authorized or contingent leave of absence without pay.
b.an employee desiring to continue his/her SHBP coverage should complete Attachment 4.5.2p5.a4. (Request to Continue Health Insurance During Leave of Absence Without Pay Form). The form will be retained in his/her medical file. Pursuant to the Rules of the SHPB, an active employee can elect to continue SHBP coverage within thirty-one (31) calendar days after beginning an unpaid leave of absence.
c.an employee on an unpaid leave of absence without pay for reasons of disability/illness (as well as family leave and military leave) will pay the same premium amount as when actively working in addition to any processing fee established by the State Board of the Department of Community Health.
d.premium payments for employees of the System Office, Quick Start Headquarters or a Quick Start Regional Office or training center shall be made directly to the System Office each month. A technical college employee shall pay his/her monthly SHBP premium directly to his/her technical college. Pursuant to SHBP Rules, an employee who fails to submit a premium payment in a timely manner will lose coverage. The System Office or technical college must notify SHBP/ADP an employee's loss of eligibility.

e. except for military leave, continued coverage outlined in Paragraph VI.G.4.a. shall not be extended/provided to an employee who is self-employed or gainfully employed by another entity during the leave of absence without pay.
f. unless otherwise provided by state or federal leave (e.g., military leave), the total period of SHBP coverage on an approved leave of absence without pay shall not exceed twelve (12) calendar months.
g. an eligible employee who did not continue SHBP coverage while on an approved leave of absence without pay which included the annual Open Enrollment period shall be offered the opportunity to enroll, discontinue, or change coverage within fifteen (15) calendar days after returning to work.

5. Flexible Benefits Program

a.an active employee who is eligible to participate in the Flexible Benefits Program may continue all insurance options in which he/she is enrolled by paying the required after-tax premium(s) during his/her approved leave of absence without pay for a period not to exceed twelve (12) calendar months. The employee will be directly billed by Georgia Breeze/ADP for all insurance option premiums. If an employee does not receive information from Georgia Breeze/ADP he/she should contact Georgia Breeze directly to make these arrangements.

b. Return from an Approved Leave of Absence Without Pay Within the Same Plan Year

1.if an employee is returning from an approved leave of absence without pay during the same Plan year in which she/she previously participated, the benefit options and coverages previously selected by the employee will be reinstated. If the employee failed to pay premiums for these insurance options and, if applicable, health care spending account contributions during the leave of absence, the System Office or technical college shall reduce the employee's salary to collect these premiums/contributions unless a contractual limitation on coverage exists.

c. Return from a Leave of Absence Without Pay Across Plan Years

1.if an employee is returning from an approved leave of absence without pay in the Plan Year following the Plan Year in which he/she previously participated, the following provisions for benefits options and coverages apply:

a.when the absence without pay is twelve (12) or less months and the employee continued premium and health care spending contributions for continuous coverage during the leave without pay period, the employee shall have an opportunity to make selection(s) pursuant to Open Enrollment provisions;

b. when the absence without pay is less than six (6) months and the employee did not pay the insurance premiums and health care spending account contributions, the employee will be provided an enrollment period. The employee can re-instate options by paying the past due insurance premiums and health care spending account contributions. The employee who chooses not to reinstate these options shall be subject to all conditions for enrollment of a current employee, such as medical underwriting, preexisting conditions and late entrant limitations; and,

c. when the absence without pay is six (6) or more months and the employee did not pay the insurance premiums and health care spending account contributions, coverages will be terminated. The employee shall be offered an opportunity to re-enroll in the same manner as is

allowed during the Open Enrollment period. The employee shall be subject to all conditions for enrollment of a current employee such as medical underwriting, preexisting conditions and late entrant requirements.

d. Return from a leave of Absence Without Pay Greater than Twelve (12) Months

1.if an employee returns from a leave of absence without pay of more than twelve (12) calendar months and the employee paid the appropriate premium amounts for the insurance options, the employee shall be offered an open enrollment period as a continuing employee.

e. Failure to Return from an Approved Leave of Absence Without Pay

1.if an employee who is on an approved leave of absence without pay fails to return to active employment or is absent more than twelve (12) months, coverage for the insurance options will terminate at the end of the month for which the premium(s) have been paid.

f. Failure to Pay Premiums While on an Approved Leave of Absence Without Pay

1.an employee's failure to pay applicable insurance option premium(s) while on a leave of absence without pay will terminate coverage at the end of the month for which the premium(s) have been paid. When premium amount(s) have not been paid, benefits will not be allowed during the period unless benefits are deliverable as a contractual provision for a total disability.

H.Creditable Service Toward Retirement

1. Teachers Retirement System of Georgia (TRS)

a.a TRS member may be eligible to establish a retirement credit for a temporary disability caused by a job-related disease or accident.

b.the maximum amount of creditable service which may be awarded is twelve (12) months and an employee must make an application for such credit within six (6) months after returning to work following a temporary disability.

c.the cost for such service credit will be the employee contributions based on the salary he/she was receiving immediately prior to the disability, plus interest.

d.in most instances the following forms will be required: the Employer's First Report of Injury Form (Attachment 4.5.2p5.a2.) and the Notice of Payment or Suspension of Benefits Form (Attachment 4.5.2p5.a3.).

2. Employees' Retirement System of Georgia (ERS)

a.an ERS member who returns to work after taking a leave of absence without pay due to certain temporary disabilities, may be eligible to receive Creditable Service for some or all of the time missed from work.

b. the amount of creditable service which may be awarded is a maximum of twelve (12) months in any five (5) year period;

c. an employee must have:

1.taken a leave of absence without pay due to either a behavioral or physical issue caused by a job-related disease or accident;

2. returned to work and applied for a service credit w/ ERS in writing;

3. paid ERS an amount equal to the applicable Employee Contribution, plus 6% interest; and;

4. made the payment within six (6) months after returning to work.

I. Return to Work

1.An employee must provide written notice of his/her intent to return to work from an authorized (regular) or contingent leave of absence without pay to the named official(s) and within the time period addressed in his/her approval notification.

2. Prior to an employee returning to duty following his/her illness, period of disability, or medical condition, he/she must provide a written release statement from his/her attending health care provider/professional indicating that he/she can return to work and perform the essential functions of his/her position/job with or without reasonable accommodation(s). If reasonable accommodation(s) are recommended, the written statement must outline the specific accommodation(s) needed.

3. An employee may request to return to work prior to the expiration of the approved leave of absence without pay. The designated official(s) may approve the request provided all terms and conditions outlined in the approval notification are met and no other factors are present that would preclude approval.

4. An employee's ability to return to work following a contingent leave of absence without pay is contingent upon the availability of a suitable vacancy as outlined in Paragraph VI.E.7.

VII. RECORD RETENTION:

All employment related documents collected pursuant to this procedure shall be maintained in a manner consistent with the Georgia Archives Retention Schedule for State Government Paper and Electronic Records and state and federal law.

EMPLOYEES' RETIREMENT SYSTEM OF GEORGIA

[Attachment: 4.5.2p5.a1.] *F7$ERS*

Group Term Life Insurance Continuation While on Leave Without Pay Form

Information for this form may be typed directly onscreen before printing. This form is not valid until received by ERSGA.

SECTION 1 - MEMBER INFORMATION

Retirement Plan Type _____ SSN _____

Last Name _____ First Name _____ Initial _____

Address _____

City _____ State _____ Zip Code _____

SECTION 2 - TERMS FOR CONTINUATION OF GTLI

I choose to continue Group Term Life Insurance (GTLI) coverage for any period during which I am on Leave Without Pay (LWOP). I understand that the following conditions apply:

- **I must have one (1) year of continuous service before I can continue my GTLI coverage while on LWOP.**
- **Premiums of one percent (1%) of the monthly salary immediately prior to my period of LWOP will accrue for each month I am on LWOP.**
- **The accrued premiums will be paid to the Employees' Retirement System as follows:**
- **At termination of state employment and on application for a refund of my contributions and interest, the premiums will be deducted from my refund;**
- **Or, at my retirement, the premiums will be deducted from my monthly benefit;**
- **Or, at my death, the premiums will be deducted from the GTLI payment to my beneficiaries.**

NOTE: If I have eighteen years of creditable service and terminate state employment and do not get a refund of my contributions and interest, GTLI coverage will continue until the ERS receives my written notification declining coverage. Any premiums accrued up until that time will be payable to the ERS by the applicable method described above.

_____

SECTION 3 -SIGNATURE & ACKNOWLEDGMENT

I have read and I understand the instructions and provisions listed above.

SIgnature **Date**

Two Northside 75 Suite 300 • Atlanta, GA 30318-7701 • PHONE (404) 350-6300 (800) 805-4609 • FAX (404) 350-6308 • www.ersga.org

WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	❑ Male ❑ Female	Birthdate	Phone Number	Employee E-mail
Address		City	State	Zip Code
EMPLOYER	Name	NAICS Code	Nature of Business (Trade, Transport, Mfg., etc.)	
Address		Phone Number	Employer FEIN	
City	State	Zip Code	Employer E-mail	
INSURER / SELF-INSURER	Name	Insurer/Self-Insurer FEIN	Insurer/ Self-Insurer File #	
CLAIMS OFFICE	Name	Claims Office FEIN #	Claims Office Phone	Claims Office E-mail
SBWC ID# (five digit no.)	Address	City	State	Zip Code

EMPLOYMENT/WAGE	Date Hired by Employer	Job Classified Code No.	Number of Days Worked Per Week	Wage rate at time of Injury or Disease: ❑ per Hour ❑ per Day ❑ per Week ❑ per Month
Insurer Type Code ❑ – Insurer ❑ S-Self-insurer ❑ Group Fund	List Normally Scheduled Days Off			

INJURY/ILLNESS & MEDICAL	Time of Injury ❑ am ❑ 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? ❑ Yes ❑ No	Did Injury/Illness Occur on Employer's premises? ❑ Yes ❑ No	Type of Injury/Illness	Body Part Affected	
How Injury or Illness / Abnormal Health Condition Occurred				

Treating Physician (Name and Address)	Initial Treatment Given: ❑ None ❑ Minor: By Employer ❑ Minor: Clinical/Hospital ❑ Emergency Room ❑ 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

❑ B. INCOME BENEFITS **Form WC-6 must be filed if weekly benefit is less than maximum**

Previously Medical Only		
❑ Yes ❑ 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:

❑ Temporary total disability ❑ Temporary partial disability ❑ 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.

❑ C. NOTICE TO CONTROVERT PAYMENT OF COMPENSATION

Benefits will not be paid because:

❑ D. MEDICAL ONLY ❑ No disability paid or controverted

Insurer / Self-Insurer: Type or Print Name of Person Filing Form	Signature	Date
Phone and Ext.	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.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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

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.

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

4. 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.

NOTICE TO INSURER / SELF-INSURER

1. Complete Section B, C, or D.
   This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form must be sent to the claimant(s) and all counsel of record. Form W-6 must be filed if weekly benefits are less than the maximum.

NOTICE TO EMPLOYEE

1. 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.**

For Information or Assistance, contact:

STATE BOARD OF WORKERS' COMPENSATION

Toll Free Telephone: 1-800-533-0682
In Atlanta: (404) 656-3818

http://www.sbwc.georgia.gov

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GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

☐ **INITIAL PAYMENT** ☐ **RE-COMMENCE** ☐ **SUSPEND** ☐ **AMENDMENT:** ☐ WC-1 Dated _____ ☐ WC-2 Dated _____

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	Employee E-mail	**EMPLOYER**	Name
Address		Address	
		City / State / Zip Code	
City / State / Zip Code		Employer E-mail	
INSURER/ SELF-INSURER	Name	Address	
CLAIMS OFFICE	Name	City / State / Zip Code	
Insurer/Self-Insurer File #	Claims Office E-mail / Phone Number	SBWC ID# (five digit no.)	

B. INCOME BENEFITS

☐ Benefits are being paid to this employee at the rate of $ _____ *per week based on an average weekly wage of $ _____

payable from ____ / ____ / ____ for:

☐ Temporary Total Disability

☐ Temporary Partial Disability

☐ Permanent Partial Disability of ____ % to _____ (Part of Body) to be paid for _____ weeks (**medical report attached**).

☐ Date of Disability _____

The date of the first check is, ____ / ____ / ____ , the amount is $ _____ , or date salary was paid ____ / ____ / ____ and this:

☐ Does not include a penalty

☐ Does include a ____ % penalty in the amount of $ _____ .

***File Form WC-6, Wage Statement, if weekly benefit is less than maximum.**

C. SUSPENSION OF BENEFITS

☐ Benefits will be suspended on ____ / ____ / ____ because:

☐ 1.) Employee returned to work on ____ / ____ / ____ without restrictions from the authorized treating physician.

☐ 2.) Employee returned to work on ____ / ____ / ____ with restrictions from the authorized treating physician at pre-injury or higher rate of pay.

☐ 3.) Employee returned to work on ____ / ____ / ____ with restrictions from the authorized treating physician at reduced pay of $ _____ per week and temporary partial disability benefits are shown in Part B above.

☐ 4.) Employee was able to return to work on ____ / ____ / ____ without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached (Board Rule 221 (i)(4)).

☐ 5.) The employee had undergone a change in condition pursuant to O.C.G.A. §34-9-104(a) (2) because the employee is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty days of the release. Temporary partial disability benefits are shown above in part B above.

☐ 6.) The employee has been offered suitable employment pursuant to O.C.G.A. §34-9-240 and has unjustifiably refused to attempt to perform the job. Form WC-240 was sent at least ten days before the employee was required to report for work. **A copy of the Form WC-240 is attached**.

☐ 7.) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid.

☐ 8.) The entire permanent partial disability benefit has been paid.

☐ 9.) The maximum of temporary partial disability payments has been paid.

☐ 10.) This claim is being controverted within sixty days of the due date of first payment. **File the Form WC-3 simultaneously and send a copy to the employee**.

☐ 11.) Other:

Insurer/Self-Insurer Type or Print Name	Signature	Date
Phone Number and ext.	E-mail	

This form must be filed with the State Board of Workers' Compensation. A copy of both sides of this form has been sent to the claimant(s) and all counsel of record.

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).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

A. OUTLINE OF BENEFITS OTHER THAN MEDICAL EXPENSE

In addition to paying your medical expenses for an injury at work, the employer will pay you for part of your lost wages if you are disabled from work for more than seven (7) calendar days because of your work-related injury.

TEMPORARY TOTAL

O.C.G.A. §**34-9-261:** IF YOU ARE NOT ABLE TO WORK AT ALL because of your injury, your employer/insurer must pay:

- 2/3 of your average weekly wage with a maximum of $525 per week if your date of accident was on or after July 1, 2013, and a maximum of $550 per week if your date of accident was on or after July 1, 2015.

- A minimum of $50.00 per week, or your actual weekly wage if less than $50.00 per week. If your accident occurred on or after July 1, 1992, and if your injury is not catastrophic, you are not entitled to this type of benefit for more than 400 weeks. Furthermore, your benefits may be reduced to those allowed by O.C.G.A. §34-9-262 under certain circumstances after you have been released to return to work with limitations or restrictions.

TEMPORARY PARTIAL

O.C.G.A. §**34-9-262:** IF YOU MUST WORK FOR LOWER WAGES because of your injury at work, your employer/insurer will pay:

- 2/3 of your wage loss (the difference between what you make after your injury and what you made before), with a maximum of $350 per week if your date of accident was on or after July 1, 2013, and a maximum of $367 per week if your date of accident was on or after July 1, 2015 for a maximum of 350 weeks from the date of accident.

PERMANENT PARTIAL

O.C.G.A. §**34-9-263:** IF YOU LOST A PART OR MEMBER OF YOUR BODY or lose the use of a member (such as arm, finger, eye, etc.), you will first receive benefits described above during disability, and then upon return to work or otherwise becoming ineligible for TTD or TPD benefits, you will receive payment for permanent partial disability for a certain number of weeks, based on the percentage of your loss. Multiply the permanent partial disability (%) by the maximum number of weeks listed below to determine the number of weeks you will receive PPD benefits. For example, for a 15% permanent partial disability to an arm, multiply 15% times 225 weeks. The answer of 33.75 represents the number of weeks you will receive income benefits.

Bodily Loss	Maximum Weeks
Arm	225
Leg	225
Hand	160
Foot	135
Thumb	60
Index Finger	40
Middle Finger	35
Ring Finger	30
Little Finger	25
Great Toe	30
Any toe other than great toe	20
Loss of hearing, traumatic	
One ear	75
Both ears	150
Loss of vision of one eye	150
Disability to the body as a whole	300

In all cases arising under the Workers' Compensation Law, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, Fifth Edition, published by the American Medical Association.

O.C.G.A. §**34-9-220:** The employer is not required to pay benefits for the first seven (7) calendar days you miss work because of your injury, unless you miss 21 consecutive days because of your injury.

O.C.G.A. §**34-9-221:** If income benefits are paid late, the employer/insurer will pay you a 15% penalty on all accrued benefits. If benefits are paid late after an award has been issued, the employer/insurer will pay you a 20% penalty.

B. RIGHT TO HEARING

If your benefits have been suspended and you believe that benefits were suspended incorrectly, you should request a hearing by sending Form WC-14 to the State Board of Workers' Compensation at the address below. If you need a Form WC-14, please contact the State Board of Workers' Compensation at the phone numbers listed below or visit the website.

STATE BOARD OF WORKERS' COMPENSATION
270 PEACHTREE STREET, N.W.,
ATLANTA, GEORGIA 30303-1299
In Atlanta: 404-656-3818
or: 1-800-533-0682
http://www.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).

Please type or print clearly in ink

Georgia Department Of Community Health
State Health Benefit Plan

P.O. Box 1990
Atlanta, Georgia 30301

Attachment: 4.5.2p5.a4.

Request to Continue Health Benefits During Leave of Absence Without Pay

I. Member and Payroll Identification.

Provide all requested information.

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence | Daytime Telephone Number ( ) Area Code

Is this form a new application or a change to a previously approved application? (Check One)
☐ New ☐ Change ☐ Extension

Department or School System

Work Unit or School

Payroll Unit Person to Contact for Information

Payroll Unit Telephone Number

State Health Benefit Plan Payroll Location Number

II. Leave Type and Payment Information.

Check leave type. Provide information requested for the leave type and payment amount.

☐ **(01) Disability/Illness -** Attach Form SHBP 66-005 from physician describing disability/illness and periods of disability from normal job duties **IS CONDITION RELATED TO PATIENT'S EMPLOYMENT?** ☐ **YES** ☐ **NO**

☐ **(02) Educational -** Actual period of instructions: **FROM:** _____ **TO:** _____

☐ **(03) Emergency Military -** Attach copy of orders.

☐ **(04) Suspension -** Attach letter from employer stating period of suspension.

☐ **(05) Family Leave -** (Check One)
☐ **Birth/Adoption** (Attach copy of letter or form approving family leave.)
☐ **Illness** (Attach copy of letter or form approving family leave and Form SHBP 66-005 or equivalent.)
Military - ☐ **Care Giver**
Military - ☐ **Called to Duty**
Period of approved family leave is: **FROM:** _____ **TO:** _____

☐ **(06) Employee's Convenience -** Will you be employed by another part or self-employed during leave? ☐ **YES** ☐ **NO**

☐ **(08) Employer's Convenience -** Attach letter from Employer From: _____ To: _____

PAYMENT INFORMATION

$ _____

You will be billed monthly - all premium payments are due by the 26th of the month prior to coverage.

III. Member Certification.

Read this section carefully. Sign and date where requested.

- I understand that health benefits may be terminated if payment is not received by the 26th of the month. I also understand that health benefits will terminate at the end of the approved leave of absence without pay or at the expiration of the time allowed by the State Health Benefit Plan unless payroll deductions are resumed.
- **I understand that application for coverage while on leave without pay must be signed within thirty-one (31) days and filed with the State Health Benefit Plan within sixty (60) days after termination of paid coverage through payroll deductions.**
- I request to continue coverage of health benefits during the period of leave of absence without pay, and I certify that all statements on this application and any attachments are correct to the best of my knowledge and belief. I further certify that I have read and agree to adhere to the conditions on the reverse side of this application. I do herby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more than $1000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

X _____ _____

Member Signature | Date

IV. Agency Certification.

Provide current coverage and leave without pay information. Sign and date where requested.

Option | Coverage

Leave Without Pay is Authorized Beginning On			Authorized Leave Ends On			Anticipated Last Payroll Deduction		
Month	Day	Year	Month	Day	Year	Month	Day	Year

The above named employee will be granted a leave of absence of the type indicated for the period shown at left.

X _____
Signature of Authorizing Official

_____ _____
Title | Date

SHBP 66-003 (Rev.02/08)

TERMS, CONDITIONS, AND INSTRUCTIONS

General Information

This form should be used to apply for continued health benefit coverage under the State Health Benefit Plan (SHBP) during a period of leave of absence without pay. The continued coverage will be governed by the **Leave Types and Time Limits** listed below, and shall be for the same coverage option and coverage type for which the employee is enrolled at the time the leave without pay commences (unless the employee qualifies for an option or coverage change under SHBP provisions). Health benefits may be continued for the period of leave, as approved by the SHBP, subject to the **Conditions and Documentation** requirements listed below. Premium payments for this continuation of coverage will be made directly to the SHBP.

Leave Types and Time Limits

Time limits for continued health benefit coverage during a period of leave of absence are considered to run concurrently. When an employee qualifies for continued coverage under multiple leave types, the total period of continuation may not exceed twelve (12) calendar months. See Family Leave for an exception

Disability leave of absence shall be for the period of the employee's disability due to illness, accident or disability, as certified by a licensed physician, not to exceed twelve (12) consecutive calendar months.

Educational leave of absence shall be for the period of educational leave not to exceed twelve (12) consecutive calendar months.

Emergency Military leave of absence shall be for the period during which an employee is ordered to military duty (not to exceed twelve (12) consecutive calendar months.)

Suspension leave of absence shall be for the period of the suspension, not to exceed twelve (12) consecutive calendar months.

Family leave of absence shall be for the period during which the employee is absent from work to care for the employee's child after birth or placement for adoption; the employee's seriously ill spouse, child, or parent; or when the employee is absent from work due to the employee's serious health condition or when an employee's spouse, son, daughter, or parent is called to active duty. The period during which coverage may be continued shall not exceed twelve (12) weeks in any (12) month period. Exception: An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember who is being a Care Giver to a recuperating servicemember due to an injury is entitled to (26) weeks in any (12) month period.

Employee's Convenience leave of absence shall be for the period of approved leave for the employee's convenience, not to exceed twelve (12) consecutive calendar months.

Conditions and Documentation

Withdrawal of employee contributions from a retirement system shall constitute resignation and approval of continued coverage during a period of leave without pay shall be terminated. The employee's eligibility for further coverage will then be governed by the extended beneficiary provisions of the plan. Documentation must be given to employer.

Disability leave: The period of disability must be certified by a licensed physician using Form SHBP 66-005. The SHBP may require additional information from the certifying physician, or may require review by another licensed physician, if the disability period is longer than the norm for the diagnosis.

Educational leave: The employee must certify the period of absence on Form SHBP 66-003. The absence may be only for the period of instruction.

Military leave: A copy of the appropriate orders must be provided.

Suspension leave: A letter stating the period of suspension, signed by the appropriate organizational official, must be provided.

Family leave: For family leave due to birth or adoption: A copy of the employer's letter or form approving the period of leave must be provided. At minimum, the form or letter must show the period of approved leave, the reason for the leave, and the date of birth or placement for adoption. For family leave due to illness of the employee or an eligible family member: A copy of the employer's letter or form approving the period of leave must be provided. Form SHBP 66-005 or a copy of the employer's physician certification form providing information equivalent to Form SHBP 66-005 must also be provided. Military: Copy of orders and disability letter from physician.

Employee's Convenience leave: The employee may not continue health benefits under the SHBP if self-employed or employed by another party during the period of leave.

Employer's Convenience leave a letter from employer stating the period of leave.

Premium Information

Premiums shall be payable monthly during the period of approved leave of absence without pay. Rates shall be subject to change upon notice at the beginning of any month during the leave period. Checks for premium payment should be made payable to "State Health Benefit Plan." Contact your personnel/payroll office or the State Health Plan Benefit for rates (which may include a processing fee).

Extensions and Continuations

An extension of leave may be requested if the employee is unable to return to work at the expiration of the approved leave and the maximum period has not been exhausted. The extension request must be signed by the employee and certified by the employing entity no later than thirty one (31) days following expiration of coverage under the approved leave of absence. The attending physician must complete the disability certification if the leave is due to disability, and the extension request must be filed with the SHBP within sixty (60) days following the expiration of coverage under the approved leave of absence.

Recurrent period of leave of absence without pay for the same or related illness shall be considered one approved leave period unless the employee returns to work and has coverage through payroll deductions for a period of three (3) consecutive calendar months.

Penalties

Failure to provide accurate information or failure to submit the appropriate premium payment(s) in a timely manner shall be cause for termination of coverage until such time as the member returns to active pay status. Failure to submit the premium payment(s) by the first of the month in which coverage is effective shall be cause for the SHBP to charge a late fee. Submission of a check that is not honored by the institution on which drawn shall be cause for SHBP to charge a processing fee or terminate coverage until the employee returns to active pay status.