BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division

PETITION FOR SETTLEMENT
(Permanent Total Disability)

Claimant INJURY/OCCUPATIONAL DISEASE

MEDICAL BENEFITS CLOSED BY SETTLEMENT ON AN ACCEPTED CLAIM

Employer

Insurer

Insurer's Primary Claim #:

Additional Claims:

ACN #(s):

The claimant suffered an injury arising from a work-related accident or occupational disease occurring on . The insurer accepted liability for the claim(s).

The claimant and insurer have agreed to settle all compensation payments due the claimant under the Workers' Compensation/Occupational Disease Acts. The claimant has agreed to accept the lump sum of: **($). Paid by the Insurer** The settlement amount shall be paid in a lump sum in addition to all sums previously paid by the insurer, unless otherwise indicated in this Petition.*

The basis for settlement of this claim is that the claimant is permanently and totally disabled as defined in the Acts. This settlement is based on the claimant's total disability benefit rate after the rate has been reduced as a result of the offset taken against the claimant's social security disability benefits, if any.

The claimant and insurer petition the Department of Labor & Industry for approval of this settlement allowing the claim to be fully and finally closed. **Coverage for medical benefits are closed by this settlement.** The **claimant**, in signing and submitting this Petition to the Department of Labor & Industry, **further understands** that if this Petition is approved, this insurer is forever released from payment of compensation, medical and hospital benefits under the Workers' Compensation and Occupational Disease Acts for the claim(s) specified above. The **claimant understands** this Petition represents a settlement and, if approved, cannot be reopened by the Department.

***Special Provisions:**

Vocational Rehabilitation Provisions:

I understand and acknowledge this settlement will end all workers' compensation coverage for medical care for the claim(s) included above and my medical benefits will terminate. I further understand this settlement of medical benefits may or may not result in secondary payers, such as Medicare, Medicaid, or health insurers, denying coverage for medical expenses for condition(s) related to the claims included above.

Claimant's Signature **Date Signed** **Witness Signature**

Claimant's Address:
Street/PO Box: City:

State: Zip Code:

Subsequent Injury Fund Certified
Yes ☐ **NO** ☐ The concurs and joins in the Petition for Settlement.

Insurer Authorized Representative **Date**

Order

The Department of Labor & Industry hereby orders that the above settlement is approved.

Dated the day of , .

Signature of Authorized Department Representative