

**BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division**

**PETITION FOR SETTLEMENT
INJURY/OCCUPATIONAL DISEASE
MEDICAL BENEFITS CLOSED**

Claimant

Employer

Insurer

Insurer's Primary Claim #:

Additional Claims

ACN Claim#:

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

The claimant and insurer have agreed to settle all compensation payments due the claimant under the Workers'
Compensation/Occupational Disease Acts. The claimant shall 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 the special provisions section of the Petition.*

The claimant and insurer petition the Department of Labor & Industry for approval of this settlement allowing the claim(s) to
be fully and finally closed. **Further medical and hospital benefits are closed by the claimant.** 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, may not 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 _____, 2019.

Signature of Authorized Department Representative