BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division

PETITION FOR SETTLEMENT
(Permanent Total Disability)
INJURY/OCCUPATIONAL DISEASE
MEDICAL BENEFITS RESERVED

Claimant

Employer

Insurer's Primary Claim #:

Additional Claims

Insurer

ACN #:

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 insurer shall pay to the claimant the sum of:
($).
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. For dates of injury prior to July 1, 1991, medical benefits are reserved. For dates of injury July 1, 1991 to June 30, 2011, medical benefits terminate when they are not used for a period of 60 consecutive months. For date of injury on or after July 1, 2011, medical benefits are reserved. 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 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:

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

Claimant's Address:

Street/PO Box:

City: State: Zip Code:

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

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