BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division

PETITION FOR SETTLEMENT
INJURY/OCCUPATIONAL DISEASE
MEDICAL BENEFITS CLOSED

Claimant

Employer

Insurer's Primary Claim #:

Additional Claims

Insurer

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:

Email Address:

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