BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division

Claimant

Employer

Insurer

PETITION FOR SETTLEMENT
INJURY/OCCUPATIONAL DISEASE
MEDICAL BENEFITS RESERVED

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. 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 will terminate 5 years from the date of the industrial accident or occupational disease. For date of injury on or after July 1, 2011, a petition to reopen the benefits for up to 5 years after termination may be submitted to the Department of Labor and Industry, Employment Relations Division, if the condition is a direct result of the compensable injury or occupational disease and requires medical treatment in order to allow the worker to continue to work or return to work. 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 **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