Department Settlement Requirements from Adjusters and/or Attorneys

*Settlement of indemnity, medical and hospital benefits on a **denied** claim:*

☐ *Denial letter*

"Petition for Settlement Disputed Initial Compensability" (Recap Sheet not required)

☐ Claimant name
☐ Insurer name
☐ Employer name
☐ Claim number
☐ Agency claim number – Adjusters have access to this number on the EPC system
☐ Date of injury
☐ Dollar amount of settlement
☐ Claimant signature & address
☐ Witness signature
☐ Date signed
☐ Authorized representative signature
☐ Attorney fees, if applicable

The Department should already have a copy of the denial letter (not just the 608 or 615 letter) but you may want to include a copy.

BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Relations Division
Does not require Recap Sheet

PETITION FOR SETTLEMENT

Claimant

DISPUTED INITIAL COMPENSABILITY

Insurer's Claim#:

Employer

ACN #:

Insurer

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

The controversy concerning the insurer's disputed liability and denial of the claim has been resolved by an agreement between the claimant and the insurer, whereby the claimant agrees to accept the lump sum of: **($)** paid by the insurer. This 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 this Petition.*

The **claimant understands**, that by entering into a settlement and signing and submitting this Petition to the Department of Labor & Industry, that if this Petition is approved, the insurer is forever released from payment of compensation, medical, and/or vocational rehabilitation benefits under the Workers' Compensation and Occupational Disease Acts for injuries or diseases claimed to have been suffered as indicated above.

The claimant and insurer petition the Department of Labor & Industry for approval of this settlement. If this settlement is approved, the claim will be forever closed and may not be reopened by the Department. **Further medical, hospital, vocational rehabilitation and all indemnity benefits are expressly closed.**

***Special Provisions:**

_____ _____

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

Claimant's Address: Email Address:

Street/PO Box:

City: State: Zip Code:

The concurs and joins in the Petition for Settlement.

Claimant's Attorney: **Insurer Authorized Representative** **Date**
Fee: $
(Do not include costs)

Order

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

Dated the day of , .

_____

Signature of Authorized Department Representative