BEFORE THE DEPARTMENT OF LABOR & INDUSTRY
Employment Standards Division

PETITION FOR SETTLEMENT
(Permanent Total Disability)
INJURY/OCCUPATIONAL DISEASE
MEDICAL BENEFITS RESERVED ON AN ACCEPTED CLAIM

_____
Claimant

_____
Employer

_____
Insurer

Insurer's Primary Claim #:
Additional Claim #(s):

ACN #(s):

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. **Further medical and hospital benefits are reserved by the claimant.** The **claimant understands** that by entering into a settlement, both the insurer and claimant agree to assume the risk that the condition of the claimant, as indicated by reasonable investigation to date, may be other than it appears or may change in the future. 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 injuries or diseases specified above. The **claimant understands** this Petition represents a settlement and, if approved, may not be reopened by the Department.

***Special Provisions:**

***Rehabilitation Provisions:**

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

Claimant's Address:
Street/PO Box:

Email Address:

City: State: Zip Code:

The _____ concurs and joins in the Petition for Settlement.

_____ _____
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

Revised 1/97