

EMPLOYMENT STANDARDS DIVISION  
SETTLEMENT/ADVANCE RECAP SHEET

Please complete the applicable sections

PETITION TITLE:

<div>1.</div> <div>CLAIMANT:</div> <div>ACN# Claim#:</div> <div>D/A or OD:</div> <div>(Include all Dates)</div> <div>INSURER PRIMARY CLAIM (S) #:</div> <div>ADDITIONAL CLAIMS</div>			
<div>2.</div> <div>DATES OF INJURY PRE 7/1/87</div> <div><div>Pre Lump Sum:</div><div>Income: \$</div><div>Expenses: \$</div><div>Differences: \$</div><div>Post Lump Sum:</div><div>Income: \$</div><div>Expenses: \$</div><div>Differences: \$</div></div> <div>For dates of injury prior to April 15, 1985: See Instructions</div> <div>For dates of injury between April 15, 1985 and June 30, 1987: See Instructions</div>			
<div>3.</div> <div>DATES OF INJURY POST 7/1/91</div> <div>703 Benefits:</div> <div>PPD Rate: \$</div> <div><div>Age: %</div><div>Education: %</div><div>Wage Loss: %</div><div>Restrictions: %</div><div>Impairment: %</div><div>Total Award: %</div></div> <div>Claimant's wage at the time of injury: \$</div> <div>Has the claimant been released to job of injury? Yes No</div> <div>Is the claimant currently working? (If yes, current wage) Yes No</div> <div>Current Wage: \$</div> <div>For Permanent Total Disability Settlements/Advances: See Instructions</div>			
<div>4.</div> <div>SETTLEMENT/LUMP SUM ADVANCE INFORMATION (ALL DATES OF INJURY)</div> <div>Impairment Rating date or MMI date (All settlements require MMI date or date released to return to work):</div> <div>Impairment Rating % Paid: Yes No</div> <div>Settlement/Advance Amount: \$</div> <div>Settlement/Advance Rationale &amp; Calculations (include present value calculations if applicable):</div>			
<div>5.</div> <div>Claimant's Signature: (or authorized representative)</div> <div>Insurer's Signature: (or authorized representative)</div> <div>TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT</div>			
<div>6.</div> <div>Claimant's Attorney:</div> <div>Fee: \$</div> <div>(Do not include costs)</div>			
<div>7.</div> <div>Reviewed by: (ESD Examiner)</div> <div>Date:</div> <div>Questions concerning this form should be addressed to: Employment Standards Division Workers' Compensation Compliance Bureau PO Box 8011 Helena MT 59604-8011 Phone (406) 444-6543</div>			