LUMP SUM SETTLEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. TYPE OF SETTLEMENT:

☐ STRUCTURED SETTLEMENT (ATTACH DOCUMENTATION)

☐ LUMP SUM SETTLEMENT
TOTAL VALUE OF SETTLEMENT $_____

19. EXPECTED FUTURE MEDICAL COSTS RELATED TO THE INJURY: $ _____

20. COMMENTS:

21. EMPLOYER/INSURER REPRESENTATIVE (TYPE OR PRINT):	22. EMPLOYEE REPRESENTATIVE (TYPE OR PRINT):

RELEASE

23. EMPLOYEE/DEPENDENT:

I AM THE PERSON ENTITLED TO WORKERS' COMPENSATION BENEFITS ON ACCOUNT OF THIS INJURY OR DEATH. I HAVE READ THIS FORM AND ALL ATTACHMENTS. I CONSENT TO THE SETTLEMENT. WHEN THE SETTLEMENT IS APPROVED BY THE ADMINISTRATIVE LAW JUDGE, I RELEASE THE EMPLOYER AND INSURER NAMED ABOVE FROM ALL FURTHER LIABILITY FOR THIS INJURY, EXCEPT AS OTHERWISE APPROVED BY THE BOARD.

_____ EMPLOYEE/DEPENDENT SIGNATURE _____ DATE _____ EMPLOYEE REPRESENTATIVE SIGNATURE _____ DATE

24. EMPLOYER/INSURER:

THE EMPLOYER CONSENTS TO THE SETTLEMENT: ☐ YES ☐ NO _____ SIGNATURE _____ DATE

THE INSURER CONSENTS TO THE SETTLEMENT: ☐ YES ☐ NO _____ SIGNATURE _____ DATE

DECISION

25. THE REQUESTED SETTLEMENT (IS/IS NOT) APPROVED. THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT THE SETTLEMENT AMOUNT OF $ _____ AND ALL OUTSTANDING COMPENSATION OBLIGATIONS INCURRED PRIOR TO THE SETTLEMENT. PAYMENT MUST BE MADE WITHIN 10 DAYS PURSUANT TO 39-A M.R.S.A. 324(1). THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT'S ATTORNEY A FEE OF $ _____. ALL PENDING PETITIONS BASED ON THIS CLAIM ARE HEREBY DISMISSED.

_____ ADMINISTRATIVE LAW JUDGE SIGNATURE _____ DATE