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

	TATE HOUSE STATION,	AUGUSTA, MAINE U	4333-002 <i>1</i>	
1. REVISION DATE: MM DD YYYY LUMP SUM SETTLEMENT			Г	2. WCB FILE NUMBER (if known):
EMPLOYEE				
3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. Ml.:	6. SOCIAL SECURIT	Y NUMBER (last 4 digits):
				, ,
7. STREET/P.O. BOX MAILING ADDRESS:	o CITY:	0 07475	XXX-XX-	11. HOME PHONE NUMBER:
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PARTS (S) AFFECTED:	
MM DD YYYY				
EMPLOYER/INSURER EMPLOYER/INSURER				
15. INSURER FILE NUMBER:	16. EMPLOYER NAME: 17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:			
18. INSURER NAME:	19.INSURER MAILING ADDR	ESS AND PHONE NUMBE	R:	
20. TYPE OF SETTLEMENT:				
STRUCTURED SETTLEMENT LUMP SUM SETTLEMENT				
(ATTACH DOCUMENTATION) TOTAL VALUE OF SETTLEMENT \$				
A SYDEOTED FUTURE MEDICAL COOTS DELATED TO THE INJURY.				
21. EXPECTED FUTURE MEDICAL COSTS RELATED TO THE INJURY: \$				
22. COMMENTS:				
22. COMMENTS.				
23. EMPLOYER/INSURER REPRESENTATIV	E (TYPE OR PRINT):	24. EMPLOYEE REPRES	SENTATIVE (TYPE OR	PRINT):
RELEASE				
25. 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.				
BT THE BOARD.				
EMPLOYEE/DEPENDENT SIGNATURE	DATE EMPL	OYEE REPRESENTATIVE SIGNAT	URE DATE	
26. EMPLOYER/INSURER:				
THE EMPLOYER CONSENTS TO THE S	ETTLEMENT: ☐ YES ☐	l no		
		SIGNATUR	RE DA	ATE
THE INSURER CONSENTS TO THE SET	FTLEMENT: \square YES \square	l no		
		SIGNATUR	RE DA	ATE
	DEC	ISION		
	DEC	ISION		
27. THE REQUESTED SETTLEMEN	NT (IS/IS NOT) APPROV	ED. THE EMPLOYE	R/INSURER IS OI	RDERED 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 JUDG	E SIGNATURE	DATE		
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The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-10 (effective 9/1/2020)