## STATE OF MAINE WORKERS' COMPENSATION BOARD 7 STATE HOUSE STATION. AUGUSTA. MAINE 04333-0027

27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027						
1. REVISION DATE:	LUMP SUM SETTLEMENT			-	2. WCB FILE NUMBER (if known):	
MM DD YYYY  EMPLOYEE						
3. EMPLOYEE LAST NAME:	4. FIRST NAME:	LOYEE	5. Ml.:	6. SOCIAL SECURIT	Y NUMBER (la	ast 4 digits):
				XXX-XX-		
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:		9. STATE:		11. HOME PHO	ONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLN	IESS:		14. BODY PARTS (S	) AFFECTED:	
// MM						
IVIIVI DD 1111	FMPI OYI	ER/INSURER				
15. INSURER FILE NUMBER:	16. EMPLOYER NAME:		17. EMPLO	OYER MAILING ADDRE	ESS AND PHO	NE NUMBER:
18. INSURER NAME:	19.INSURER MAILING ADDRES	SS AND PHONE	NUMBER:			
20. TYPE OF SETTLEMENT:						
STRUCTURED SETTLEMENT (ATTACH DOCUMENTATION)  LUMP SUM SETTLEMENT TOTAL VALUE OF SETTLEMENT \$						
21. EXPECTED FUTURE MEDICAL COSTS RELATED TO THE INJURY: \$						
22. COMMENTS:						
23. EMPLOYER/INSURER REPRESENT	24. EMPLOYE	24. EMPLOYEE REPRESENTATIVE (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.						
EMPLOYEE/DEPENDENT SIGNATURE	DATE EMP	PLOYEE REPRESENT	TATIVE SIGNAT	URE DATE		
26. EMPLOYER/INSURER:						
THE EMPLOYER CONSENTS TO TI	HE SETTLEMENT:	□ NO				
THE INCHES CONSENTS TO THE	- OFTE EMENT	7 NO	SIGNATUR	RE DA	ATE	
THE INSURER CONSENTS TO THE	ESETTLEMENT: LI YES L	□ NO	SIGNATUR	RE DA	ATE	
DECISION						
27. 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.						

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 (eff. 9/1/20)

DATE

ADMINISTRATIVE LAW JUDGE SIGNATURE