ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act ___ Occupational Diseases Act ___ Fatal case? No ___ Yes ___ Date of death _____________

____ Case #

Employee/Petitioner

v.

____ Setting ______________________________

Employer/Respondent

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

____

Employee's name Street address City, State, Zip code

____

Employer's name Street address City, State, Zip code

State Employee? Yes ____ No ____ Male ____ Female ____ Married ____ Single ____

Dependents under age 18 _____ Birthdate _______________ Average weekly wage $ _______________

Date of accident __________________

How did the accident occur? ____

What part of the body was affected? ____

What is the nature of the injury? ____

The employer was notified of the accident orally ____ in writing ____ . Return-to-work date __________________

Location of accident ____________________________ Did the employee return to his or her regular job? Yes ___ No ___
If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for _________ weeks at the rate of $ _________ /week.

The employee was temporarily totally disabled from ___________________________ through ___________________________

MEDICAL EXPENSES: The employer has ____ has not ____ paid all medical bills. List unpaid bills in the space below.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered

in writing to pay the petitioner $ _________________ as compensation for the permanent disability caused by this injury.

An arbitrator or commissioner of the Commission previously made an award on this case on ____________________ regarding

TTD ______________ Permanent disability _____________ Medical expenses ____________ Other ____________

TERMS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee.

Total amount of settlement $ _______________

Deduction: Attorney's fees $ _______________

Deduction: Medical reports, X-rays $ _______________

Deduction: Other (explain) $ _______________

Amount employee will receive $ _______________

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.* I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

Signature of petitioner | Name of petitioner (please print) | Telephone number | Date

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

Signature of attorney | Date

Attorney's name and IC code # (please print)

Firm name

Street address

City, State, Zip code

Telephone number | E-mail address

RESPONDENT'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney or agent | Date

Attorney's name and IC code # or agent (please print)

Firm name

Street address

City, State, Zip code

Telephone number | E-mail address

Name of respondent's insurance or service company (please print)

ORDER OF ARBITRATOR OR COMMISSIONER:
Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case.