

**AGREEMENT AS TO COMPENSATION**  
Workers' Compensation Claim No. \_\_\_\_\_

**IF THIS FORM IS NOT PROPERLY COMPLETED, THE SETTLEMENT WILL NOT BE APPROVED.**  
Every section should be completed. If a section is not applicable, fill in the blank with N/A.

\_\_\_\_\_  
Plaintiff/Employee

\_\_\_\_\_  
Insurer/Self-Insured/Self-Insurance Group

\_\_\_\_\_  
Social Security Number/Green Card

\_\_\_\_\_  
Insurer's Mailing Address

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
City, State, Postal Code

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Additional Defendant Name

\_\_\_\_\_  
City, State, Postal Code

\_\_\_\_\_  
Additional Defendant Mailing Address

\_\_\_\_\_  
Defendant/Employer

\_\_\_\_\_  
Additional Defendant City, State, Postal Code

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Additional Other Defendant Name

\_\_\_\_\_  
City, State, Postal Code

\_\_\_\_\_  
Additional Other Defendant Mailing Address

\_\_\_\_\_  
Additional Other Defendant City, State, Postal Code

**INJURY**

Date of Injury: \_\_\_\_\_

Where did injury occur:

City/State/Postal Code:

\_\_\_\_\_

Brief description of occurrence resulting in injury:

\_\_\_\_\_

Causes of Injury: \_\_\_\_\_

Body parts affected: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_

**MEDICAL INFORMATION**

Medical expenses paid: \$ \_\_\_\_\_ Date of last medical payment: \_\_\_\_\_

Medical expenses unpaid or contested: \$ \_\_\_\_\_

Surgery performed: Yes No

Nature of Surgery: \_\_\_\_\_

Impairment ratings considered in settlement:  
(Attach entire medical report that provides ratings)

Impairment	Date Given	Physician
_____ %	_____	_____
_____ %	_____	_____
_____ %	_____	_____
_____ %	_____	_____
_____ %	_____	_____
_____ %	_____	_____

Restrictions on activities:

Attach most recent medical report setting forth physical restrictions.

Diagnoses: \_\_\_\_\_

If medical treatment is continuing, attach a copy of the executed Form 113 indicating a designated physician.

**WORK INFORMATION**

Does plaintiff/employee qualify for increased benefits under KRS 342.730 (1)(c)1 or 2? Yes No

Explain: \_\_\_\_\_

Yes  No Has the plaintiff/employee filed for Social Security Disability or Supplemental Security Income benefits?

Yes  No If "No", does the plaintiff/employee intend to file for Social Security Disability or Supplemental Security Income benefits?

Type of work performed at time of injury: \_\_\_\_\_

Average Weekly Wage at time of injury: \$ \_\_\_\_\_

Type of work performed after injury: \_\_\_\_\_

Wages upon returning to work: \$ \_\_\_\_\_ Post-injury return-to-work date: \_\_\_\_\_

Type of work performed at time of settlement: \_\_\_\_\_

### **BENEFIT AND SETTLEMENT INFORMATION**

**Amount and duration of temporary total disability paid to date:**

Beginning Date	End Date	\$ per week	# of weeks	Total

**For each lump sum or income benefit agreed to, show your calculation below:**

Type				
Responsible party				
Frequency of payments				
Start Date				
Weekly payment rate				
Impairment Rating				
Grid Factor				
Multiplier				
Payment amount				
Number of Weeks (for income benefits)				
Present Value (for lump sums)				
Total				

Total of Lump Sum and Income Benefits: \_\_\_\_\_

**Are the following waivers included in the monetary settlement?**

Waiver or buyout of past medical benefits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Amount for Waiver(s)</u> \$ _____
Waiver or buyout of future medical benefits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
(if yes, attach most current medical report or office note from treating physical)			
Waiver of vocational rehabilitation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Waiver of right to reopen	Yes	No	\$ _____

Total of Waivers: \_\_\_\_\_

**Monetary terms of settlement:**

Beginning Date	Payment Amount	Frequency	# of Payments	Total Value
Total Settlement				

If settlement terms provide for a lump sum representing weekly benefits greater than \$100, does claimant have an adequate source of income during disability  Yes  No

Source of income: \_\_\_\_\_

Weekly amount: \$ \_\_\_\_\_

**OTHER INFORMATION**

If additional information is pertinent to the settlement, please explain (additional information may be attached to this form if required):

\_\_\_\_\_

Other responsible parties against whom further proceedings are reserved:

\_\_\_\_\_

**If waiving medical benefits**, please acknowledge by signing below:

I understand that my health insurance may not cover any medical expenses for my injury and I may be held responsible for payment of medical expenses for my injury. I further state I understand and have been advised medical benefits pursuant to the Kentucky Workers' Compensation Act are payable for the cure and/or relief of the effects of the injury without limitation as to time. I have not been promised that any entity will automatically pay for medical expenses related to my injury. I have conferred with my treating physician about medical treatment I may require in the future and I am satisfied that the amount being paid for the waiver of future medical benefits is adequate to provide for that treatment.

\_\_\_\_\_  
Plaintiff/Employee Signature

**If not represented by an Attorney**, please acknowledge by signing below:

I understand that I have a right to obtain an Attorney of my choice to review this Agreement and by signing below I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an Attorney and this Agreement will be enforceable as if represented by Attorney.

\_\_\_\_\_  
Plaintiff/Employee Signature

\_\_\_\_\_  
Attorney for Plaintiff/Employee Signature

\_\_\_\_\_  
Attorney for Plaintiff/Employee Name typed

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, Postal Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Plaintiff/Employee Signature

\_\_\_\_\_  
Attorney for Defendant/Employer Signature

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, Postal Code

\_\_\_\_\_  
Telephone Number

**Other Participating Parties:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ORDER APPROVING SETTLEMENT AGREEMENT**

**IT IS HEREBY ORDERED** that the above Agreement as to Compensation is **APPROVED**.

This the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
**Administrative Law Judge**