

**AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT**

Workers' Compensation Claim No. \_\_\_\_\_  
Before \_\_\_\_\_

**IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.**  
**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 Street 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

**HEARING LOSS OR OCCUPATIONAL DISEASE**

Occupational disease: \_\_\_\_\_ Injury Type: \_\_\_\_\_

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

Cause of disease: \_\_\_\_\_

Brief description of history of exposure:  
\_\_\_\_\_  
\_\_\_\_\_

Length of exposure: \_\_\_\_\_ Date of last exposure: \_\_\_\_\_

Where did exposure occur:  
City/State/Postal Code:  
\_\_\_\_\_

**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:

Pulmonary function studies considered in settlement:  
(Attach entire medical report that provides ratings)

FVC	FEV1	Date of Study	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Diagnosis:

<u>ILO Classification</u>	<u>Date of Report</u>	<u>Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:

\_\_\_\_\_

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?

Yes  No

Type of work performed at last exposure: \_\_\_\_\_

Average Weekly Wage at last exposure: \$ \_\_\_\_\_

Type of work performed after return to work: \_\_\_\_\_

Wages upon returning to work: \$ \_\_\_\_\_ 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 weekly income benefit payment 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?**

Amount for Waiver(s)

Waiver or buyout of past medical benefits       Yes      No      \$ \_\_\_\_\_

Waiver or buyout of future medical benefits      | Yes|      | No|      \$ \_\_\_\_\_  
 (if yes, attach most current medical report or office note from treating physical)

Waiver of vocational rehabilitation       Yes       No      \$ \_\_\_\_\_

Waiver of right to reopen       Yes       No      \$ \_\_\_\_\_

**Monetary terms of settlement:**

Beginning Date (for periodic payments only)	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: \$ \_\_\_\_\_

Does settlement include retraining incentive benefits?     Yes     No

If yes, is claimant actively participating in instruction or training program?     Yes     No

Name of instruction or training program (attach explanatory pages if necessary):

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**OTHER INFORMATION**

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

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Other responsible parties against whom further proceedings are reserved:

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

I understand that my health insurance may not cover any medical expenses for my injury, hearing loss, or occupational disease and I may be held responsible for payment of medical expenses. 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, hearing loss, or occupational disease without limitation as to time. I have not been promised that any entity will automatically pay for medical expenses related to my injury, hearing loss, or occupational disease. 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**