

**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 _____

Employee/Petitioner

Case # _____

v.

Employer/Respondent

Setting _____

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: Petitioner's cost \$ _____
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, except as otherwise provided herein, 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
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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.

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	Date
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Signature of attorney or agent	Date
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Attorney's name and IC code # (please print)

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

Firm name

Firm name

Street address

Street address

City, State, Zip code

City, State, Zip code

Telephone number	E-mail address
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Telephone number	E-mail address
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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.