STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**LUMP SUM SETTLEMENT**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE NAME:	4. SOCIAL SECURITY # (last 4 digits): XXX-XX-	5. EMPLOYEE ADDRESS:
6. DATE OF INJURY:	7. SPECIFIC INJURY OR ILLNESS:	8. BODY PARTS (S) AFFECTED:

EMPLOYER/INSURER

9. EMPLOYER NAME:	10. EMPLOYER MAILING ADDRESS:
11. INSURER NAME:	12. INSURER FILE NUMBER:

13. TYPE OF SETTLEMENT:

☐ STRUCTURED SETTLEMENT
PRESENT VALUE OF SETTLEMENT $_____

☐ LUMP SUM SETTLEMENT
TOTAL VALUE OF SETTLEMENT $_____

14. COMMENTS:

RELEASES

15. **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 _____ TYPE OR PRINT

_____ EMPLOYEE REPRESENTATIVE SIGNATURE _____ DATE _____ TYPE OR PRINT

16. **EMPLOYER:**

THE EMPLOYER WAS NOTIFIED OF SETTLEMENT: ☐ YES ☐ NO OBJECTION: ☐ YES ☐ NO

THE EMPLOYER CONSENTS TO THE SETTLEMENT: _____ EMPLOYER REPRESENTATIVE SIGNATURE _____ DATE _____ TYPE OR PRINT

17. **INSURER:** THE INSURER CONSENTS TO THE SETTLEMENT:

_____ INSURER REPRESENTATIVE SIGNATURE _____ DATE _____ TYPE OR PRINT

DECISION

18. 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.
EXPECTED FUTURE MEDICAL COSTS $ _____.

_____ ADMINISTRATIVE LAW JUDGE SIGNATURE _____ DATE

FOR INTERNAL USE ONLY:

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.