

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD

COMPROMISE AND RELEASE

Case No(s). _____

Social Security No. _____

Applicant (Employee)

Address

Correct Name(s) of Employer(s)

Address(es)

Correct Name(s) of Insurance Carrier(s) Claims Administrator(s)

Address(es)

I. The employee, born _____, claims that he/she was employed at _____,
_____, as a(n) _____ by the employer(s), and claims to have sustained
(state) (city)
(occupation)
injury(ies) arising out of and in the course of employment:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

on _____ to _____

on _____ to _____

on _____ to _____

on _____ to _____

on _____ to _____

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.
3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 despite any language to the contrary in this document or any addendum.

Applicant/Employee: _____ WCAB No(s). _____

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph No. 7. Any addendum duplicating this language pursuant to Sumner v WCAB, 48 CCC 369 (1983), is unnecessary and shall not be attached.
5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.
6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY \$ _____

TEMPORARY DISABILITY INDEMNITY PAID \$ _____ Weekly Rate \$ _____

Period(s) Paid _____

PERMANENT DISABILITY INDEMNITY PAID \$ _____ Weekly Rate \$ _____

Period(s) Paid _____

TOTAL MEDICAL BILLS PAID \$ _____ Total Unpaid Medical Expense to be Paid By: _____

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the **SUM OF \$** _____. The following **amounts are to be deducted** from the settlement amount:

\$ _____ for permanent disability advances through _____
(date)

\$ _____ for temporary disability indemnity overpayment, if any.

\$ _____ payable to _____

\$ _____ payable to _____

\$ _____ payable to _____

\$ _____ payable to _____

\$ _____ requested as applicant's attorney's fee.

LEAVING A BALANCE OF \$ _____, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code §5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

Applicant/Employee: _____ WCAB No(s). _____

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). **ISSUES NOT INITIALED BY ALL PARTIES ARE NOT INCLUDED WITHIN THIS SETTLEMENT.**

- ___ ___ earnings
- ___ ___ temporary disability
- ___ ___ jurisdiction
- ___ ___ apportionment
- ___ ___ employment
- ___ ___ injury AOE/COE
- ___ ___ serious and willful misconduct
- ___ ___ discrimination (Labor Code §132a)
- ___ ___ statute of limitations
- ___ ___ future medical treatment
- ___ ___ other _____
- ___ ___ other _____
- ___ ___ permanent disability _____
- ___ ___ self-procured medical treatment, except as provided in Paragraph 7
- ___ ___ vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS

Any accrued claims for Labor Code Section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the WCAB may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the WCAB may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING OR MAY BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this _____ day of _____, 20____, at _____

Witness 1 (Date)

Applicant (Employee) (Date)

Witness 2 (Date)

Attorney for Applicant (Date)

Interpreter (Date)

Attorney for Defendant (Date)

STATE OF CALIFORNIA
County of _____

(Date)

On this ___ day of _____, 20___, before me, _____, a Notary Public in and for the said County and State, residing therein, duly commissioned and sworn, personally appeared _____ known to me to be the person(s) whose name(s) is/are subscribed to the within Instrument, and acknowledged to me that he executed the same.

In Witness Whereof, I have hereunto set my hand and affixed my official seal the day and year in this Certificate first above written.