LAB 500

THE STATE OF NEW HAMPSHIRE
DEPARTMENT OF LABOR
CONCORD NH 03301

LUMP SUM SETTLEMENT AGREEMENT

Claimant's SS No.
Employer's ID No.______________________________
(9-digit number assigned by proper Federal Agency)
Insurance Carrier________________________________
(Number)

with a mailing address
(Name of Claimant or Dependent) (Number and Street)

City or Town of____________________ State of Zip Code

and____
(Name of Employer or Insurance Company)

OfficeAddress
(Name and Street) (City or Town) (State)
hereby acknowledge they have reached a mutual resolution of the matters in dispute between them arising from an injury which occurred on______________,_____, while the claimant
(Date)
was employed by____________________________ In accordance with the provisions of
(Name of Employer)
RSA 281-A:37, the parties jointly request approval of the settlement of $ to be paid in a lump sum.

Social Security offset (if applicable).

____

______________________________ ______________________________
WITNESS: CLAIMANT:

(Print Name) (Print Name)

______________________Date______________________________Date________
(Signature) (Signature)

EMPLOYER OR INSURANCE COMPANY
(Authorized By and Title)
____________________ Date
(Signature)

The above request for the payment of Lump Sum Settlement is hereby approved.

Commissioner or Commissioner's Representative Date Approved

Attorney Fees and Expenses totaling $ are hereby approved.
Initial

LUMP SUM SETTLEMENT QUESTIONNAIRE

RSA 281-A:37 provides that lump sum settlement agreements for at work injuries may be permitted at the discretion of the Labor Commissioner or his designated representative when it is in the best interest of all concerned. Please provide the following information for the Department's consideration in reviewing the proposed lump-sum settlement.

Claimant_______________________________________ Date of Birth_____________________
Attained Age_____________________

CurrentAddress

Employer_______________________________________ Date of Injury___________________

Comp Rate $ AWW $ Carrier_________________________________

Claimant Attorney (if applicable)

Carrier Attorney (if applicable)

Have there been any hearings at the Department? (Y) or (N)

Ifyes, when?

Is there an appeal pending? (Y) or (N) What is the status of appeal?

1. What is the claimant's current medical status? Please summarize briefly, then attach all current physician office notes, surgical reports, and any IME reports. ("Previously submitted" is not an acceptable answer to this question.)

2. What specific date of injury is being settled?
   If there's more than one date of injury and it does not involve a recurrence, a separate lump sum settlement proposal must be completed and submitted.

3. What specific injury(ies) and/or condition(s) are being settled?

4. Has the treating physician released the claimant to work? (Y)   (N)
   Full-Time   or Part-Time______________________
   Full-Duty____________________   or Light-Duty______________________
   Is the claimant working? (Y) _________   or (N) _____________

5. Briefly outline the claimant's <u>education</u> and <u>work</u> history.

6. Are there barriers to employment? (e.g., language, non-work
   related condition(s), etc.) (Y)________   (N)____________
   If yes, please list:

7. Has a Permanent Impairment Award been previously approved by the Department?
   (Y)__________   (N)__________
   If not, has there been a determination of permanent impairment that is included in this
   settlement? (Y)_________   (N)__________
   If yes, please <u>attach</u> the supporting medical report(s).

8. Are there are outstanding medial bills? (Y)   (N)
   a) List all bills that are to be paid as a condition of settlement.
   b) List all bills that remain in dispute and may become an issue for formal
      hearing at a later date.

9. What, if any, vocational rehabilitation services have been provided to the
   claimant?

10. What are the claimant's vocational/employment prospects or plans?

11. Has application been made or is the claimant receiving Social Security Disability
    benefits? (Y)_________   (N)___________
    If yes: a) When were they first applied for?
            b) When was the first payment received?

12. Is a third-party action pending or anticipated? (Y) (N)

If yes: a) is the claimant aware of the carrier's lien on future net third party proceeds? (Y) ______ (N) _____
b) is the claimant aware of the "Holiday" provisions in the event of future medical treatment? (Y) _____ (N) _____

13. Has a third-party settlement been approved by either the Superior Court or Department of Labor? (Y) _____ (N) _____
If yes, attach a copy of the approval order and workers' compensation carrier's confirmation of lien.

14. Please check any additional issues that are applicable to this settlement and attach all documentation to substantiate such.

a) NH Child Support Lien
b) Social Security Offset _____
c) Third Party Settlement _____
d) Annuity Settlement and/or Payout Provisions _____
e) Vocational Rehabilitation Escrow Amount $__________
f) Trust or Guardianship
g) Second Injury fund/Concurrent Wages Application _______
h) Attorney Lien(s) $___________
i) IRS Lien $___________
j) Mediation Expense $__________
k) Other (Specify) ______________

15. In regards to this date of injury, will the claimant's representative or counsel continue to assist the claimant on follow-up medical bill hearings at the Department?

16. Is the claimant under any pressure by anyone to lump-sum settle his/her claim at this time?
(Y) _____ (N) _____
If yes, please explain.

17. Please provide the rationale and calculations that form the basis for this settlement proposal. If a vocational rehabilitation plan is included in these calculations, a copy of the approved rehabilitation plan must be attached:

RATIONALE: (The reason why this case should be settled at this time).

CALCULATIONS: (List the actual figures for each item considered in the settlement. Add them and show the TOTAL SETTLEMENT). Note: If the carrier has waived all or part of its lien in a third party settlement, the amount waived must be included as part of the total settlement figure. For example, a payment of $10,000.00 to the claimant plus the waiver of a lien $14,500 = $24,500 total settlement.

Claimant's Affidavit: I have read and understood all questions posed by this proposal and have no further questions as of the date of the lump sum settlement.

Claimant's Signature

Claimant's Attorney's Signature (if applicable)

Date

Date

Carrier/Employer Representative Signature

Date

CLAIMANT'S AFFIDAVIT

This is to attest that I have been fully apprised of my rights under RSA 281-A, the Workers' Compensation law.

I understand that all my injured employee rights, including, but not limited to the following are forgone upon the Department of Labor signature on the Lump Sum Settlement.

RSA 281-A:23-b	Alternative Work Opportunities
RSA 281-A:25	Vocational Rehabilitation
RSA 281-A:25-a	Reinstatement of Employee Sustaining Compensable Injuries
RSA 281-A:28	Compensation for Temporary Total Disability
RSA 281-A:28-a	Compensation for Permanent Total Disability
RSA 281-A:31	Compensation for Temporary Partial Disability
RSA 281-A:31-a	Compensation for Permanent Partial Disability
RSA 281-A:32	Scheduled Permanent Impairment Award
RSA 281-A:48	Review of Eligibility for Compensation, Extent of Disability

However, pursuant to RSA 281-A:23, Medical, Hospital and Remedial Care, or RSA 281-A:23-a, Managed Care, I have not forgone any future entitlement for medical care in settling my workers' compensation claim. I additionally understand that the carrier, third party administrator, self-insured or employer has a right to controvert any future claims for Medical, Hospital and Remedial Care as it may relate to my claim(s) for any at-work injury if it should determine that such treatment is not reasonable or made necessary by such claims for any at-work injury.

Date

Witness Claimant