pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
WORKERS' COMPENSATION OFFICE OF ADJUDICATION

COMPROMISE AND RELEASE AGREEMENT BY STIPULATION PURSUANT TO SECTION 449 OF THE WORKERS' COMPENSATION ACT

EMPLOYEE SOCIAL SECURITY NUMBER OR WC ID NUMBER
XXX - XX - ____ ____

DATE OF INJURY
__ __ - __ __ - __ __ __ __
MM DD YYYY

WCAIS CLAIM NUMBER
____ ____ ____ ____ ____ ____ ____

EMPLOYEE

First name _____
Last name _____
Date of birth _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____

NOTICE: SUBMIT TO THE ASSIGNED WORKERS' COMPENSATION JUDGE.

TO THE EXTENT THIS AGREEMENT REFERENCES AN INJURY FOR WHICH LIABILITY HAS NOT BEEN RECOGNIZED BY AGREEMENT OR BY ADJUDICATION, THE TERM "INJURY" AS USED IN THIS AGREEMENT SHALL MEAN "ALLEGED INJURY."

"FUND" SHALL MEAN THE UNINSURED EMPLOYERS GUARANTY FUND (UEGF), SUBSEQUENT INJURY FUND (SIF), SELF-INSURANCE GUARANTY FUND (SIGF) OR THE PREFUND ACCOUNT OF THE SELF-INSURANCE GUARANTY FUND.

EMPLOYER

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____

INSURER, FUND or THIRD PARTY ADMINISTRATOR (if self-insured)

Name _____
Address _____
Address _____
City/Town _____ State ____ ZIP _____
County _____
Telephone _____ FEIN _____
NAIC code _____ or Insurer code _____
Insurer/TPA claim # _____

This is an agreement in the case of the above listed employee and the above listed employer, insurer, Fund or third party administrator in regards to an injury or occupational disease under the Workers' Compensation Act only.

1. State the **date of injury** or occupational disease. __ __ - __ __ - __ __ __ __ (MM DD YYYY)
2. State the **average weekly wage** of the employee, as calculated under Section 309. $ _____ . _____ /wk
3. State the **weekly compensation rate** paid or payable. $ _____ . _____ /wk
4. State the precise **nature of the injury** and whether the disability is total or partial.
5. State the amount of benefits paid or due and unpaid to the employee or dependent up to the date of this agreement or death. **Wage Loss: $_____ . _____** **Specific Loss: $_____ . _____** **Medical: $_____ . _____**

6. Is this Compromise and Release Agreement a resolution of **wage loss benefits** for the injury referenced in paragraphs 1 and 4?
☐ Yes ☐ No

7. Is this Compromise and Release Agreement a resolution of **medical benefits** for the injury referenced in paragraphs 1 and 4?
☐ Yes ☐ No

8. Is this Compromise and Release Agreement a resolution of **specific loss benefits** for the injury referenced in paragraphs 1 and 4?
☐ Yes ☐ No

9. Does this claim arise out of the death of an employee? ☐ Yes ☐ No
If **yes**, complete and attach a **Death Claim Supplement**.

10. Summarize all **wage loss**, **specific loss** and **medical benefits** to be paid in conjunction with this Compromise and Release Agreement:

11. Is there an actual or potential lien for subrogation under Section 319? ☐ Yes ☐ No
If **yes**, state (if known) the total amount of compensation, including medicals, paid or payable, which would be allowed to the employer or insurer.

12. Are there any current child or spousal support orders in place against the employee? ☐ Yes ☐ No

Verification pursuant to Special Rules of Administrative Practice and Procedure before Workers' Compensation Judges, Rule 131.111(c), must be submitted into evidence as required by Act 109 of 2006 and in the manner prescribed by the adjudicating Workers' Compensation Judge.

If yes, provide details:

13. List all benefits received by, or available to the employee: e.g., Social Security (disability or retirement), private health insurance, Medicare, Medicaid, etc.

14. This Compromise and Release Agreement addresses the interests of **Medicare** in accordance with the Medicare Secondary Payer Statute (42 U.S.C. Section 1395(y)):

(a) Manner in which Medicare's interests have been addressed:

(b) Amount allocated: $_____ . _____ .

(c) Manner in which **conditional payments** have been addressed:

15. Check as appropriate:

☐ A vocational evaluation of the employee was completed in conjunction with this Compromise and Release Agreement on

_____ - _____ - _____ by _____ .

A copy of this report must be attached.

-OR-

☐ A vocational evaluation of the employee has been waived by mutual agreement of the parties.

16. State the **issues** involved in this claim and the reasons why the parties are entering into this agreement.

17. **A copy of the fee agreement between employee and counsel must be attached.**
State the amount of the fee: $_____ . _____ .

18. **Litigation costs** in the total amount of $_____ . _____ shall be the responsibility of _____ .

19. State **additional terms and provisions**, if any:

<u>REMINDER TO PARTIES</u>: Upon approval of the agreement, please promptly withdraw all appeals which are also resolved by this agreement.

EMPLOYEE'S CERTIFICATION

1. I certify that I have read this entire agreement, or to the best of my knowledge, information and belief (if applicable) this agreement has been read to me, and I understand all the contents of this agreement as well as the full legal significance and consequences of entering into this agreement to compromise and release my workers' compensation benefits under the Pennsylvania Workers' Compensation Act only.

2. I understand that, if this agreement is approved, I will receive only the benefits mentioned in this agreement, unless the agreement provides specifically for additional amounts. I understand that my employer, its insurance company or its administrator will never have to pay any other workers' compensation benefits under the Pennsylvania Workers' Compensation Act for the injury.

3. Except for the amounts of benefits listed in this agreement, I have been offered nothing of value to convince me to sign this agreement.

4. I have been represented by an attorney of my own choosing during this case. My attorney has explained to me the content of this agreement and its effects upon my rights to workers' compensation benefits under the Pennsylvania Workers' Compensation Act. _____ (Employee's initials)

   -OR-

   I have not been represented by an attorney of my own choosing. However, I have been told that I have the right to be represented by an attorney of my own choosing in this proceeding. I have made my own decision not to have an attorney represent me. _____ (Employee's Initials)

5. Unless specifically stated in this agreement, I understand that this agreement is a compromise and release of a workers' compensation claim under the Pennsylvania Workers' Compensation Act only, and is not considered an admission of liability by employer and/or insurer and/or administrator and/or Fund.

DO NOT SIGN THIS DOCUMENT UNLESS YOU UNDERSTAND THE FULL LEGAL SIGNIFICANCE OF THIS AGREEMENT

All parties have read this agreement and agree to its contents. We understand that under this agreement, **all petitions are resolved unless specifically agreed to herein**. A list of any petitions or issues that remain open after approval of the Compromise and Release Agreement must be provided in this agreement.

DATE

	-	-
MM	DD	YYYY

_____
Employee's signature

_____
Employee's counsel signature

_____
Fund/Employer/Insurer/Third Party Administrator's signature

_____
Witness to employee's signature

_____
Fund/Employer/Insurer/Third Party Administrator counsel's signature

_____
Witness to employee's signature

_____
Fund/Employer/Insurer/Third Party Administrator counsel's signature

If not witnessed above, this agreement must be notarized as follows:

AFFIDAVIT/ACKNOWLEDGMENT:

Before me, the undersigned notary public, in and for the aforesaid county and state, personally appeared _____ who being first duly sworn, does depose and state that he/she knows (or has satisfactorily proven to be) the individual identified as the employee in the foregoing compromise and release agreement; and that he/she has executed the foregoing compromise and release agreement for the purposes stated herein:

_____
Notary Public

THE COMPROMISE AND RELEASE AGREEMENT IS NOT VALID AND BINDING UNLESS APPROVED BY A WORKERS' COMPENSATION JUDGE WHOSE ROLE IS TO DETERMINE THAT THE EMPLOYEE UNDERSTANDS THE FULL LEGAL SIGNIFICANCE OF THIS AGREEMENT.

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Employer Information Services
717.772.3702

Claims Information Services
toll-free inside PA: 800.482.2383
local & outside PA: 717.772.4447

Hearing Impaired
PA Relay 7-1-1

Email
ra-li-bwc-helpline@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program