Reset Form Print Form

# STATE OF CALIFORNIA
# DIVISION OF WORKERS' COMPENSATION
# WORKERS' COMPENSATION APPEALS BOARD
# THIRD PARTY
# COMPROMISE AND RELEASE

Case Number 1

Case Number 4

Case Number 2

Case Number 5

Case Number 3

SSN (Numbers Only)

**Venue Choice is based upon: (Completion of this section is required)**

☐ County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

☐ County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

☐ County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

**Employee (Completion of this section is required)**

First Name

MI

Last Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

**Employer (Completion of this section is required)**

Name (Please leave blank spaces between numbers, names or words)

Address/PO Box (Please leave blank spaces between numbers, names or words)

City

State

Zip Code

**Applicant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Defendant's Attorney or Authorized Representative:**

☐ Law Firm/Attorney ☐ Non Attorney Representative

First Name

Last Name

Firm Number

Law Firm Name

Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Insurance Carrier Information (If applicable - include even if carrier is adjusted by claims administrator)**

Insurance Carrier Name (Please leave blank spaces between numbers, names or words)

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

**Claims Administrator Information (If applicable)**

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

The parties hereto, for the purpose of compromise only, hereby submit the following agreed statements of fact:

1. _____ ,

born on _____ (MM/DD/YYYY) claims that he was employed on the _____ day of _____ (Month) , _____ (Year) at

_____ (city) , _____ State as a(n)

_____ (Occupation) by

_____ (Name of employer) then insured as

to workers' compensation liability by _____ (State name of carrier or whether self insured) ,

sustained an injury arising out of and in the course of his employment as follows:

2. The actual weekly wages of the employee at the time of injury were $ _____

while the average weekly wages were $ _____ .

3. The employee's present disability is _____ (State present disability resulting from injury)

and the employee _____ returned to work _____ (If so when) .

4. (a) Temporary disability indemnity has been paid to the employee in the sum of $ _____

at $ _____ per week covering _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY)

the amount due and unpaid to the employee is $ _____ .

(b) Permanent disability indemnity has been paid to the employee in the sum of $ _____

covering period from _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY) .

5. Medical and hospital expenses have been paid $ _____ by the employee and $ _____

by employer or carrier. Unpaid bills amount to $ _____ . Future medical and hospital expense

is estimated at $ _____ . Unpaid and future medical and hospital expense is to be assumed as follows:

6. Name and address of employee's attorney, if any

_____

Law Firm or Company Name (If Applicable)

_____ ____

Attorney/Rep First Name MI

_____

Attorney/Rep Last Name

_____ _____

Address/PO Box (Please leave blank spaces between numbers, names or words) Suite/Apt#

_____ _____ _____

City State Zip Code

7. It is claimed that the injury to the employee was caused by the negligence of

_____

An agreement has been reached for settlement in full of the employee's claim for personal injury against said alleged tort-feasor for the sum of $ _____ .

8. Copy of settlement agreement between employee and the alleged tort-feasor is attached. ☐ Yes ☐ No

(Copy must be attached if in writing, or explanation given)

9. From said sum the employee's attorney requests a fee of $ _____ and $ _____ for expenses incurred [Note attach supporting statements, e.g. Court agreement, services rendered, etc. See Labor Code section 3860(f)] leaving a balance of $ _____ to be divided between the employee and the

_____ . To Employee $ _____ .

(Carrier or Self insured)

To: _____ ☐ Court approval documents attached

(Carrier or Self insured)

to carrier or self insured employer $ _____ .

10. Reason for compromise (include issues that would be raised in event of proceedings under provisions of paragraph 13)

11. The undersigned request that this compromise Agreement and Release be approved.

12. Upon approval of this Compromise Agreement by the Workers' Compensation Appeals Board and payment in accordance with the provisions hereof, said employee releases and forever discharges said employer and insurance carrier from all claims and cause of action, whether now known or ascertained, or which may hereafter arise or develop as a result of said injury, including any and all liability of said employer and said insurance carrier and each of them to the dependents, heirs, executors, representatives, administrators or assigns of said employee.

13. It is agreed by all parties hereto that the filing of this document is the filing of an application on behalf of employee and that the workers' compensation administrative law judge may in his or her 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 date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve said Compromise Agreement and Release or disapprove the same and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

14. For the purpose of determining the lien claim filed herein for the unemployment compensation disability benefits or unemployment compensation benefits and extended duration benefits which have been paid under or pursuant to the California Unemployment Insurance Code, the parties propose the following division of the sum agreed upon for settlement and release of this case.

$ _____ for temporary disability covering the period _____ to _____ .

$ _____ for accrued medical expense paid or incurred by the employee.

$ _____ for future medical care.

$ _____ for permanent disability.

(The above segregation must be fair and reasonable and must be based on the real facts of the case. There should be no attempt made to deprive the lien claimant of a reasonable recovery consistent with all the amounts involved. W.C.A.B Rule 10886 requires proof of service of a copy of this agreement on such lien claimant.)

**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 questions he/she may have had about this agreement answered to his/her satisfaction.

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

| | | | |
|---|---|---|---|
| Witness 1 | (Date) | Applicant (Employee) | (Date) |
| Witness 2 | (Date) | Attorney for Applicant | (Date) |
| Interpreter | (Date) | Attorney for Defendant | (Date) |
| | | Attorney for Defendant | (Date) |

# ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ **(Seal)**

**INSTRUCTIONS**

**1. If the injured employee is under 18 years of age and a guardian ad litem has not been previously appointed, a petition for appointment of guardian ad litem and trustee must accompany this agreement.**

**2. The guardian must sign this agreement on behalf of an injured employee who is under 18 years of age. If minor is above the age of 14 such minor should also sign this agreement.**

**3. Kindly attach all medical reports not previously submitted to the Workers' Compensation Appeals Board.**

**4. Also attach a copy of the agreement with the third party tort-feasor, if such agreement is in writing.**