

STATE OF COLORADO
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION CLAIM(S) SETTLEMENT AGREEMENT

WC No(s):

Carrier No(s):

IN THE MATTER OF THE WORKERS' COMPENSATION CLAIMS:

, Claimant,

v.

, Employer

and

, Carrier/Self-Insured

, Insurer/Respondents.

The parties named above have disputes regarding the amount of Workers' Compensation Benefits, if any, to which Claimant may be entitled. Because they wish to avoid the expense and uncertainty of litigation, the parties wish to FOREVER settle this matter and therefore state and agree as follows:

1. Claimant sustained or alleges injuries or occupational diseases arising out of and in the course of employment with the employer on or about _____ including, but not limited to _____.

Other disabilities, impairments and conditions that may be the result of these injuries or diseases but that are not listed here are, nevertheless, intended by all parties to be included in and resolved FOREVER by this settlement.

2. In **full and final** settlement of all benefits, compensation, penalties and interest to which Claimant is or might be entitled as a result of these alleged injuries or occupational diseases, Respondents agree to pay and Claimant agrees to accept the following \$ _____,

in addition to all benefits that have been previously paid to or on behalf of the Claimant. This amount will be reduced by the total amount owed by Claimant as indicated in any Writ of Garnishment, Notice of Administrative Lien and Attachment or any other legally authorized procedure served upon Respondent(s) for court-ordered support pursuant to §8-42-124 C.R.S. All parties agree that this settlement is not an admission of liability by the Respondents.

3. As consideration for the amount paid under the terms of this settlement, Claimant rejects, waives, and forever gives up the right to claim all compensation and benefits to which Claimant might be entitled for each injury or occupational disease claimed here, including but not limited to the following, unless specifically provided otherwise in paragraph 9A of this agreement:

a. Temporary total and temporary partial disability benefits to compensate the Claimant for time missed from work and _____

b. Permanent total disability benefits payable to the Claimant for life if the Claimant is totally incapable of earning any wages and _____

- c. Permanent impairment (also known as vocational impairment, medical impairment or permanent partial disability) benefits, payable up to a maximum amount of \$168,677.59 and
- d. A lump sum payment of up to \$84,339.86 against an award of permanent impairment or permanent total disability and
- e. Vocational rehabilitation benefits, including job training, income maintenance or any other benefits payable as vocational rehabilitation and
- f. Benefits of up to \$9,678.66 for disfigurement, scarring, discoloration, and/ or a limp, and
- g. All penalties, interest, costs, and attorneys' fees up to the date this settlement is approved by the Division. The parties do not waive the right to seek post-approval penalties should either side fail to comply with the terms of the approved settlement agreement.
- h. Medical, surgical, hospital, and all other health care benefits, including chiropractic care and mileage reimbursement incurred after the date of the approval of this settlement agreement by the Division of Workers' Compensation or by an administrative law judge from the Office of Administrative Courts.

4. The parties stipulate and agree that this claim will never be reopened except on the grounds of fraud or mutual mistake of material fact.

5. Respondents specifically retain waive their subrogation rights.

6. Claimant realizes that there may be unknown injuries, conditions, diseases or disabilities as a consequence of these alleged injuries or occupational diseases, including the possibility of a worsening of the conditions. In return for the money paid or other consideration provided in this settlement, Claimant rejects, waives and FOREVER gives up the right to make any kind of claim for workers' compensation benefits against Respondents for any such unknown injuries, conditions, diseases, or disabilities resulting from the injuries or occupational diseases, whether or not admitted, that are the subject of this settlement. The Claimant and Respondents agree that this settlement, when approved by the Division of Workers' Compensation or by an administrative law judge from the Office of Administrative Courts, ends FOREVER the Claimant's right to receive any further workers' compensation money and benefits even if the Claimant later feels that Claimant made a mistake in settling this matter or later regrets having settled.

7. Claimant understands that **this is a final settlement** and that approval of this settlement by the Division of Workers' Compensation or by an administrative law judge from the Office of Administrative Courts dismisses this matter with prejudice and FOREVER closes all issues relating to this matter. Claimant is agreeing to this settlement of Claimant's own free will, without force, pressure or coercion from anyone. Claimant is not relying upon any promises, guarantees, or predictions made by anyone as to Claimant's physical or mental condition; the nature, extent, and duration of the injuries or occupational diseases or as to any other aspect of this matter.

8. Neither Claimant nor Respondents intend to waive or give up any available rights, claims, privileges or defenses by signing this Settlement Agreement **unless and until** it is approved by the Division of Workers' Compensation or by an administrative law judge from the Office of Administrative Courts. The parties acknowledge and agree that approval by the Division of Workers' Compensation or by an administrative law judge from the Office of Administrative Courts applies only to those matters set forth in this agreement that are subject to the *Workers' Compensation Act* and that the approval by the Division or by an administrative law judge from the Office of Administrative Courts has no effect on any separate or contingent agreement(s) that the parties may have reached.

9. A.)

B.)

C.)

10. This settlement agreement contains the entire agreement between the parties and shall be binding upon the parties when approved by the Division of Workers' Compensation or by an administrative law judge from the Office of Administrative Courts.

When applicable, the statement below is to be completed by the *interpreter* and the interpreter is to sign where appropriate and include the interpreter's PRINTED name and complete address.

I, _____ (interpreter) affirm that on this ____ day of _____, 201____, I read this document in its entirety to the individual whose name appears below as the claimant in this settlement in that person's native language and that the person indicated to me that person understood each and every term of the settlement and, by signing this agreement, consents to and accepts the settlement as written.

Interpreter's Name (please print)

Interpreters Signature

Interpreter's address (print please): _____

Claimant's Name (please print)

Claimant's Signature

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me this _____ day of _____, 20 ____.

by _____
Print name of Notary Public

Signature of Notary Public

My commission expires: _____



Claimant Attorney: _____
Claimant Attorney Printed Name

Claimant Attorney Signature

Claimant Attorney Registration Number

Respondent Attorney: _____
Respondent Attorney Printed Name

Respondent Attorney Signature

Respondent Attorney Registration Number

**DIVISION OF WORKERS' COMPENSATION
CHOICE OF SETTLEMENT ADVISEMENT**

Claimant Name: _____

Workers' Compensation No.: _____

Check the ***one*** that applies:

Represented:

I have been advised of my rights by my attorney regarding settlement and am requesting immediate approval of the settlement agreement.

Self-represented (check **one**):

I have not been advised of my rights regarding settlement and am requesting an in-person or telephonic advisement by division staff.

OR

I have not been advised of my rights regarding settlement and am waiving my right to an advisement. By checking this box and signing the form, I hereby affirm:

I have reviewed the online advisement regarding settlements available on the Division's website.

I understand my rights and obligations with regard to this settlement agreement, including the right to an in-person advisement conducted by division staff.

I understand that I have three (3) business days from the date I sign this form to contact the Division of Workers' Compensation and withdraw this waiver. If I withdraw the waiver, I understand the settlement will not be approved until I attend an in-person or telephonic advisement.

I affirm that I have been offered nothing of value for waiving my right to an in-person advisement.

Signature of Claimant

Print Name

Date

If advisement is waived, this document must be notarized

Subscribed and sworn to before me this _____ day of _____, _____.



Notary Public

In and for _____ County
and _____ State.

My commission expires _____.

For use by a language interpreter, if necessary: I, _____ (print name of interpreter) affirm that on this _____ day of _____, _____, I read this document in its entirety to the individual whose name appears above in that person's native language, and that the person indicated an understanding of each and every provision contained on this form. _____ (Signature)