COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR & INDUSTRY
BUREAU OF WORKERS' COMPENSATION
1171 S. CAMERON STREET, ROOM 103
HARRISBURG, PA 17104-2501
(TOLL FREE) 800.482.2383
TTY 800.362.4228
www.dli.state.pa.us

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

Date of Injury: _____/_____/_____
MM DD YYYY

PA BWC Claim Number: _____
(IF KNOWN)

Employee

First Name	Last Name	
Street 1		
Street 2		
City/Town	State	Zip Code
County	Telephone (____) _____- _____	

Employer

Name		
Street 1		
Street 2		
City/Town	State	Zip Code
County		
Telephone (___) _____-_____	FEIN	

Insurer, Fund or Third Party Administrator (if self-insured)

Name		
Street 1		
Street 2		
City/Town	State	Zip Code
County		
Telephone (___) _____-_____	Bureau Code	
Insurer/TPA Claim Number	FEIN	

TO THE PARTIES: DO NOT SUBMIT THIS AGREEMENT TO THE BUREAU. SUBMIT IT 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 UEGF, SIF, SIGF OR PRE-SIGF.

This form must be used as of February 1, 2011. Prior versions of the form will no longer be accepted.

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.

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 should be allowed to the employer or insurer.

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

    Verification pursuant to Special Rules of Administrative Practice and Procedure before Workers' Compensation Judges, Rule 131.111(c), <u>must</u> be attached.

    If Yes, provide details:

13. List all **benefits** received by, or available to, the claimant; 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 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 responsibilty of _____.

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

REMINDER TO PARTIES: Upon approval of this Agreement, please promptly withdraw all appeals pending before the Workers' Compensation Appeal Board, Commonwealth Court, Pennsylvania Supreme Court, etc., 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 of the contents of this agreement as well as the full legal significance and consequences of entering into this agreement.

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 for the injury.

3. Except for the amounts or 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. _____ (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, 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.

Dated: _____ / _____ / _____
MM DD YYYY

_____
EMPLOYEE (SIGNATURE)

_____
WITNESS TO EMPLOYEE'S SIGNATURE

_____
EMPLOYEES COUNSEL (SIGNATURE)

_____
WITNESS TO EMPLOYEE'S SIGNATURE

_____
FUND/EMPLOYER/INSURER/THIRD PARTY ADMINISTRATOR (SIGNATURE)

_____
FUND/EMPLOYER/INSURER/THIRD PARTY ADMINISTRATOR COUNSEL(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 IN A DECISION.

Any individual filing misleading or incomplete information knowingly and with intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act and may also be subject to criminal and civil penalties through Pennsylvania Act 165.

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