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| FORM 110-IInjuryRevised February 2020 | KENTUCKY DEPARTMENT OF WORKERS’ CLAIMSFrankfort, KY 40601 |  |
|  | **AGREEMENT AS TO COMPENSATION****AND****ORDER APPROVING SETTLEMENT** |  |
|  | Workers’ Compensation Claim No. |  |  |
|  | **IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE DISAPPROVED.** |  |
|  | Every Section should be filled in. If a section is not applicable, fill in the blank with N/A.A separate Form 110 is required for each claim number in a consolidated case. |  |
|  |  |  |
| Claimant Name |  | Insurer/Self-Insured/Self-Insurance Group Name |
|  |  |  |  |
| SSN/Green Card | Date of Birth |  | Insurer Mailing Address |
|  |  |  |
| Claimant Mailing Address |  | Insurer City, State, Zip Code |
|  |  |  |
| Claimant City, State, Zip Code |  | Other Participating Party Name |
|  |  |  |
| Claimant E-mail Address |  | Other Participating Party Mailing Address |
|  |  |  |
| Employer Name |  | Other Participating Party City, State, Zip Code |
|  |  |  |
| Employer Mailing Address |  |  |
|  |  |  |
| Employer City, State, Zip Code |  |  |
|  |  |  |
| **INJURY** |
|  |  |  |  |
| Injury Date: |  | Location (City, County, State): |  |
| Body part(s) affected: |  |
| Nature of Injury(ies): |  |
| Brief description of occurrence resulting in injury: |
|  |

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| **MEDICAL INFORMATION** |
| Medical expenses paid: $ |  | Date of last medical payment: |  |
| Medical expenses unpaid or contested: $ |  |  |
| Surgery performed: (check one) |[ ]  Yes |[ ]  No | Nature of surgery: |  |
|  |  |  |  |
| Impairment ratings: (Attach entire medical report that provides ratings) |
|  |  |  |  |
|  |  |  | Date Given |  | Physician |
|  | % |  |  |  |  |
|  | % |  |  |  |  |
|  | % |  |  |  |  |
|  |  |  |  |
| Diagnosis or diagnoses: |
|  |
| Restrictions on activities – Attach most recent medical report setting forth physical restrictions. |
| **If medical treatment is continuing, attach a copy of the executed Form 113 indicating a designated physician.** |
|  |  |  |  |
| **WORK INFORMATION** |
| Type of work performed at time of injury: |  |
| Average weekly wage at time of injury: $ |  | Date of return to work after injury: |  |
| Wages upon return to work: $ |  | Type of work performed after injury: |  |
| Type of work performed at time of settlement: |  |
| Does plaintiff/employee qualify for increased benefits under KRS 342.730(1)(c) 1 or 2? |[ ]  Yes |[ ]  No |
| **BENEFIT AND SETTLEMENT INFORMATION** |
|  |  |  |  |
| **TTD:** Paid from |  | to |  | @ $ |  | \* |  | = $ |  |
|  | Date |  | Date |  | Amount |  | # of weeks |  | Total |
| **PPD/PTD:** Monetary terms of settlement: |  | paid in lump sum, or |  | weekly for |
|  |  | weeks. |  |  |
| Settlement computation: |  |
|  | TTD\*IMP RATING\*AMA FACTOR\*MULTIPLIER\*DISC FACTOR OR # OF WKS = TOTAL |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Waiver(s):** |  |  |  |  | Amount for waiver |
| Waiver or buyout of past medical benefits |[ ]  Yes |[ ]  No |  |
| Waiver or buyout of future medical benefits |[ ]  Yes |[ ]  No |  |
| Waiver of vocational rehabilitation |[ ]  Yes |[ ]  No |  |
| Waiver of right to reopen |[ ]  Yes |[ ]  No |  |
|  |  |  |
| **MSA:** |[ ]  Yes |[ ]  No |  |
|  | If yes, amount of Medicare Set Aside |  |  |
|  |  | Lump Sum |  |
|  | Periodic payments: |  | \* |  | \* |  | = |  |  |
|  |  | Amount |  | Frequency |  | Duration |  | Total |  |
|  |  |  |
| **Total Settlement:** |  | + |  | = |  |  |
|  | Income Benefits |  | Waivers |  | Total |  |
|  |  |  |
| **If settlement terms provide for lump sum representing weekly benefits greater than $100, does claimant have** |
| **an adequate source of income during disability?** |[ ]  Yes |[ ]  No |
| Source of income: |  | Amount: $ |  |
|  |  |  |
| **OTHER INFORMATION** |
| If additional information is pertinent to settlement, explain below: |
|  |
| Other responsible parties against whom further proceedings are reserved: |
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| **If waiving medical benefits,** please acknowledge by signing below: |
| I understand that my health insurance may not cover any medical expenses for my injury and I may be held responsible for payment of medical expenses for my injury. I understand and have been advised that medical benefits under the Kentucky Workers Compensation Act are payable for the cure and/or relief of my work injury although possibly subject to time limitation. I have not been promised that any entity will automatically pay for medical expenses related to my injury. I have conferred with my treating physician about medical treatment I may require in the future and am satisfied that the amount being paid for the waiver of future medical benefits is adequate to provide for that treatment. |
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|  | Plaintiff/Claimant Signature |  |
| **If not waiving medical benefits in a claim subject to 780-week benefit limit,** please acknowledge by signing below: |
| I understand that the Defendant/Employer or its insurance carrier remains liable for reasonable and necessary medical benefits related to my injury, but that the liability is potentially limited as explained below. The Defendant retains the right to challenge medical treatment by filing a medical dispute. I will receive notice of such a challenge by a Motion to Reopen and Form 112/Medical Dispute.The Defendant’s obligation to pay medical benefits will expire 780 weeks from the date of my injury unless I have applied for and been granted a continuation of medical benefits. The Department of Workers Claims will mail to me a notice letter twenty-six (26) weeks before the 780-week anniversary date of my injury explaining that the Defendant’s liability for medical benefits will expire on that date unless I successfully apply for an extension. It is my responsibility to notify the Department of Workers Claims of any changes to my physical or electronic mailing addresses to ensure I receive this notice letter. My application for continuation of medical benefits must be filed within 75 days prior to the termination of the 780-week allowance for medical benefits.  |
|  |  |  |
|  | Plaintiff/Claimant Signature |  |
| **If not represented by an Attorney,** please acknowledge by signing below: |
| I understand that I have a right to obtain an Attorney of my choice to review this Agreement and by signing below; I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an Attorney and this Agreement will be enforceable as if represented by Attorney. |
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|  | Plaintiff/Claimant Signature |  |

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| Plaintiff/Claimant Signature |  |  |
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| Attorney or representative for claimant (Signature) |  | Attorney or representative for employer (Signature) |
|  |  |  |
| Attorney or representative for claimant (Name typed) |  | Attorney or representative for employer (Name typed) |
|  |  |  |
| Mailing Address |  | Mailing Address |
|  |  |  |
| City, State, Zip Code |  | City, State, Zip Code |