FORM 110-ODHLCWP
Hearing loss/Occ. Disease
Revised February 2020

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, 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

SSN/Green Card Date of Birth

Claimant Mailing Address

Claimant City, State, Zip Code

Claimant E-mail Address

Employer Name

Employer Mailing Address

Employer City, State, Zip Code

Insurer/Self-Insured/Self-Insurance Group Name

Insurer Mailing Address

Insurer City, State, Zip Code

Other Participating Party Name

Other Participating Party Mailing Address

Other Participating Party City, State, Zip Code

HEARING LOSS OR OCCUPATIONAL DISEASE: INJURIOUS EXPOSURE

Occupational Disease: _____ Cause of Disease: _____

Date of last exposure: _____ County in which exposure occurred: _____

Body part(s) affected: _____

Length of exposure: _____

Brief description of history of exposure:

_____

_____

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 at last exposure: _____

Average weekly wage at time of last exposure: $ _____ Date of return to work: _____

Wages upon return to work: $ _____ Type of work performed after return: _____

Type of work performed at time of settlement: _____

BENEFIT AND SETTLEMENT INFORMATION

TTD: Paid from _____ (Date) to _____ (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: $ _____

Does settlement include retraining incentive benefits? ☐ Yes ☐ No

If yes, is claimant actively participating in instruction or training program? ☐ Yes ☐ No

Name of instruction or training program (Attach additional pages if necessary):

_____

_____

_____

OTHER INFORMATION

If additional information is pertinent to settlement, explain (Attach additional pages if necessary):

_____

_____

_____

_____

_____

_____

Other responsible parties against whom further proceedings are reserved:

_____

_____

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.

_____
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.

_____
Plaintiff/Claimant Signature

Plaintiff/Claimant Signature

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