



The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 7470 in Mass. Outside Mass. - 617-727-4900 ext. 7470
http://www.mass.gov/dia

DIA Board #
(If Known):

AGREEMENT FOR REDEEMING LIABILITY
BY LUMP SUM UNDER G.L. CH. 152
FOR INJURIES OCCURRING ON OR AFTER NOV. 1, 1986

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Please Print or Type

EMPLOYEE \_\_\_\_\_ LUMP SUM AMOUNT \$ \_\_\_\_\_

EMPLOYER \_\_\_\_\_ TOTAL DEDUCTIONS \$ \_\_\_\_\_

INSURER \_\_\_\_\_ NET TO CLAIMANT \$ \_\_\_\_\_

BOARD NUMBER \_\_\_\_\_ TOTAL PAYMENTS \$ \_\_\_\_\_
(Weekly benefits plus lump sum)

DATE OF INJURY \_\_\_\_\_

CHECK WHERE APPLICABLE

- ( ) Liability has been established by acceptance or by standing decision of the Board, the Reviewing Board, or a court of the Commonwealth and this settlement shall not redeem liability for the payment of medical benefits and vocational rehabilitation benefits with respect to such injury.
( ) Liability has NOT been established by standing decision of the Board, the Reviewing Board, or a court of the Commonwealth and this settlement shall redeem liability for the payment of medical benefits and vocational rehabilitation benefits with respect to such injury.
( ) In addition to the lump-sum, the insurer agrees to pay all outstanding reasonable and related medical bills incurred as of this date.
( ) The employee is currently receiving a cost-of-living adjustment.

DEDUCTIONS: From the lump-sum amount as stated above, the amount(s) listed below will be deducted and paid directly to the following parties:

Table with 3 columns: Amount (\$), NAME, ADDRESS. Rows include Attorney's Fee, Attorney's Expenses, Liens, Inchoate Rights, and empty rows for additional deductions.

(OVER)

**EMPLOYEE MEDICAL INFORMATION:**

Age \_\_\_\_\_ No. of Dependents \_\_\_\_\_ Average Weekly Wage \$ \_\_\_\_\_ Compensation Rate \$ \_\_\_\_\_

Social Security No.\*: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_ Educational Background \_\_\_\_\_

On Social Security: YES ( ) NO ( )

On Public Employee Disability Retirement: YES ( ) NO ( )

DIAGNOSIS \_\_\_\_\_ PRESENT MEDICAL CONDITION \_\_\_\_\_

\_\_\_\_\_

Present Work Capacity: \_\_\_\_\_ Third Party Action \_\_\_\_\_

**PLEASE GIVE A BRIEF HISTORY OF THE CASE AND INDICATE WHY THE SETTLEMENT IS  
IN THE EMPLOYEE'S BEST INTEREST (Specify all allocations):**

(Please attach a separate sheet if necessary.)

Received of \_\_\_\_\_ the Lump Sum of \_\_\_\_\_  
\_\_\_\_\_ dollars and \_\_\_\_\_ cents (\$\_\_\_\_\_)

This payment is received in redemption of the liability of all weekly payments now or in the future due me under the Workers' Compensation Act, for all injuries received by \_\_\_\_\_ on or about \_\_\_\_\_ while in the employ of \_\_\_\_\_  
\_\_\_\_\_. **I fully understand that after all of the deductions herein I will receive \$\_\_\_\_\_. I am fully satisfied with and request approval of this settlement. This agreement has been translated for me into my native language of \_\_\_\_\_.**

**SIGNATURE**

**ADDRESS**

**ZIP CODE**

**CLAIMANT:** \_\_\_\_\_

**CLAIMANT'S COUNSEL:** \_\_\_\_\_

**INSURER'S COUNSEL:** \_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

\*Disclosure of Social Security Number is Voluntary. It will aid in the processing of this document.