



The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2107
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, SEC. 48
FOR INJURIES OCCURRING BEFORE NOV. 1, 1986

Page 1 of 2
Please Print or Type

Board Number Employee
Insurer Or Self-insurer Employer
Insurer's Address

LUMP SUM AMOUNT \$

Total Deductions \$ Net to Claimant \$

Total Payments \$ Insurer's Claim Number

Received of the Lump Sum of

dollars and cents (\$) making with weekly payments

already received by me , the total sum of dollars and cents (\$).

Said payments are received in redemption of the liability for 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

subject to the approval of the Department of Industrial Accidents.

Claimant's Signature

Witness's Signature

Claimant's Address

Witness's Address

Signature of Insurer's Rep.

Date of Agreement

STRIKE OUT IF NOT APPLICABLE

I understand that from the LUMP SUM amount stated above, the amounts listed below will be deducted and paid to the following parties:

- 1. \$ Attorney's Fee Name Address
2. \$ Liens
3. \$
4. \$
5. \$
6. \$
7. \$

STRIKE OUT IF NOT APPLICABLE

I understand that, in addition to the LUMP SUM amount stated above, the insurer or self-insurer will pay all outstanding reasonable medical bills incurred as of this date:

I understand that after all of the above deductions, including attorneys fees and other liens, I will receive the net amount of \$. I further understand that this is a complete and final settlement of my claim and that I will not be able to reopen my claim or seek further benefits because of this injury. I am fully satisfied with this settlement.

Claimant's Signature and Date

(over)

Witness's signature and Date

Employee: Age: _____ Average Weekly Wage: _____ Dependents: _____ Comp. Rate: _____
Social Security No.*: _____ On Social Security Disability: Yes ___ No ___
Occupation: _____ If yes, from what date?: _____

Injury: Nature: _____
Place and Date of all injuries included _____
Cause: _____

Liability: Accepted: Yes ___ No ___ If No, state reason _____

If accepted, what is pending issue: _____

Medical: Original Diagnosis: _____

Present Medical Condition: _____
Present Work Capacity: _____

PERTINENT MEDICAL REPORTS AND BILLS SHOULD BE ATTACHED HERETO

COMPENSATION PAID: \$34 \$ _____ \$35A \$ _____ \$34A \$ _____
\$35 \$ _____ \$36 \$ _____ \$31 \$ _____

PLEASE GIVE A BRIEF HISTORY OF THE CASE AND INDICATE WHY THE SETTLEMENT IS IN THE EMPLOYEE'S BEST INTEREST (Specify any requested allocation of claimant's net amount):

Signatures:

Counsel for Insurer

Counsel for Employee