



*Please print or type*

**AGREEMENT UNDER SECTION 37 or 37A**

**Please Note** – For Injuries on or after 12/23/1991, the insurer must file their quarterly request for reimbursement within two (2) years from the date of the final approval of the Form 123. All subsequent quarterly request for reimbursements must be received by the DIA within two (2) years from the date of payment by the insurer.

<b>E M P L O Y E E</b>	1. Employee's Name (Last, First, MI):	
	2. Home Address (No. & Street, City, State, Zip Code):	
	3. Employer's Name:	
	4. Employer's Address (No. & Street, City, State, Zip Code):	
<b>I N S U R E R</b>	5. Insurance Carrier's Name:	6. Insurance Company Address:
	7. Name & Address of Person Able to Verify Information:	
	8. Telephone Number:	

9. Paid Through (mm/dd/yyyy):	10. First Date of Disability (mm/dd/yyyy):	11. If Employee Died, Enter Date of Death:
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12. Total Amount to be reimbursed under Section 37  or 37A : \$ \_\_\_\_\_ (Check all that apply  NEGOTIATED to this agreement)  FULL & FINAL

13. Amount of Quarterly Reimbursements (if any): \$ \_\_\_\_\_

14. Is employee still receiving weekly compensation benefits? Yes  No  If Yes, please fill out the following

<u>TYPE OF WEEKLY COMPENSATION</u>	<u>COMPENSATION AMOUNT</u>
a. <input type="checkbox"/> Total Disability – Temporary (§34)	\$ _____
b. <input type="checkbox"/> Total Disability – Permanent (§34A)	\$ _____
c. <input type="checkbox"/> Partial Disability (§35)	\$ _____
d. <input type="checkbox"/> Dependent Coverage (§35A)	\$ _____
e. <input type="checkbox"/> Surviving Dependents Coverage (§31)	\$ _____
f. <input type="checkbox"/> Other (Specify) _____	\$ _____

I hereby certify that the information contained herein is a true accounting of all payments made to the above named employee.

_____ Signature of Insurer's Authorized Representative		_____ Prepared Date (mm/dd/yyyy)
_____ Name & title (Last, First, MI)		
I hereby agree to and approve the following reimbursement to be made per the provisions of this agreement.		
_____ Signature for the Office of Legal Counsel	_____ Date (mm/dd/yyyy)	_____ Name & title (Last, First, MI)
I hereby agree to and authorize the following reimbursement to be made per the provisions of this agreement.		
_____ Signature for the Office of the Director	_____ Date (mm/dd/yyyy)	_____ Name & title (Last, First, MI)