FORM 117

The Commonwealth of Massachusetts
Department of Industrial Accidents
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 Inside Mass. / (857) 321-7470 Outside Mass.
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

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.

Based on the employee's age _____ and life expectancy of _____ years, this net settlement of $ _____ represents payment to the employee of $ _____ per month for life pursuant to Sciarotta v. Bowen, 837 F.2d. 135 (3d Cir., 1988).

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

	NAME	ADDRESS
1. $_____ Attorney's Fee	_____	_____
2. $_____ Attorney's Expenses	_____ (Please attach documentation)	_____
3. $_____ Liens	_____ (Please attach discharges)	_____
4. $_____ Inchoate Rights	_____ (Please specify release)	_____
5. $_____	_____	_____
6. $_____	_____	_____
7. $_____	_____	_____

(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.