FORM 117A

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, § 48 FOR INJURIES OCCURRING BEFORE NOV. 1, 1986

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:

	Amount	Name	Address
1.	$____________ Attorney's Fee	____________	____________
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

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