FORM 123

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 123
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750
Info. Line (800) 323-3249 in Mass. / (857) 321-7470 Outside Mass.
www.mass.gov/dia

DIA BOARD NO.
§37 or §37A Claim

Please print or type.
All fields are required.

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.

EMPLOYEE

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):

INSURER

5. Insurance Carrier's Name:
6. Insurance Company Address:
7. Name, Address & Tel. # of Person Able to Verify Information:
8. DIA Board Number of underlying claim:
8a. If 3rd party, docket #/Court
8b. Policy No. for underlying claim

9. Paid Through (mm/dd/yyyy):
10. First Date of Disability (mm/dd/yyyy):
11. If Employee Died, Enter Date of Death:

12. Total Amount to be reimbursed under Section 37 ☐ or 37A ☐ : $_____ (Check all that apply to this agreement) ☐ NEGOTIATED ☐ 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

TYPE OF WEEKLY COMPENSATION	COMPENSATION AMOUNT
a. ☐ Total Disability – Temporary (§34)	$_____
b. ☐ Total Disability – Permanent (§34A)	$_____
c. ☐ Partial Disability (§35)	$_____
d. ☐ Dependent Coverage (§35A)	$_____
e. ☐ Surviving Dependents Coverage (§31)	$_____
f. ☐ 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)