FORM	19
	ß

The Commonwealth of Massachusetts Department of Industrial Accidents – Department 19 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)

## **SECTION 19 AGREEMENT**

1. Employee's Name (Last, First, MI) and Addres	. Employee's Name (Last, First, MI) and Address (No., Street, City, State, Zip):			2. Social Security Number*:	
3 Employer/Address (No., Street, City, State, Zip	):				
4. Insurer/Address (No., Street, City, State, Zip):				5. Date of Injury (mm/dd/yyyy)	
Now come the parties	in the above-reference	d action	n and agree to the	following on a:	
Without Pr	ejudice	With Prejudice			
Without Lis	ability	With Liability			
Does this agreement close out the If the answer is no, what issues ren		No	Not Applicable		
This someone sut do.			ing any other drives	and a fama as	
Employee/Claimant Signature:	es not forfeit the parties' rig	gnis to ra		Date (mm/dd/yyyy):	
8. Employee Counsel Signature:			9. 1	Date (mm/dd/yyyy):	
). Insurer Counsel/Claims Rep. Signature:			11. I	Date (mm/dd/yyyy):	
	APPROVAL FOR THE	DEPART	MENT BY:		
NAME:	TITLE:			DATE:	

\*Disclosure of Social Security Number is Voluntary. It will aid in the processing of your claim.

Form 19 - 7/2019 - Reproduce as needed.

## SECTION 19 AGREEMENT FILING INSTRUCTIONS

## PENALTIES UNDER M.G.L.c. 152 § 8(1) SHALL RESULT IF PAYMENT, PURSUANT TO THIS AGREEMENT, IS NOT MADE WITHIN 14 DAYS OF THE INSURER'S RECEIPT OF THE APPROVED DOCUMENT. THE ORIGINAL FORM MUST BE FILED WITH THE DEPARTMENT AND WILL NOT BE RETURNED TO THE PARTIES.

Use Additional Space If Necessary