



The Commonwealth of Massachusetts
Department of Industrial Accidents

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http://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

Page 1 of 2
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:

Table with 3 columns: Amount, Name, Address. Rows include Attorney's Fee, Attorney's Expenses, Liens, Inchoate Rights.

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.