FORM 110
INJURY
October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
657 Chamberlin Avenue, Frankfort, Kentucky 40601

AGREEMENT AS TO COMPENSATION

Workers' Compensation Claim No._____

IF THIS FORM IS NOT PROPERLY COMPLETED, THE SETTLEMENT WILL NOT BE APPROVED.
Every section should be completed. If a section is not applicable, fill in the blank with N/A.

_____
Plaintiff/Employee

_____
Social Security Number/Green Card

_____
Date of Birth

_____
Mailing Address

_____
City, State, Postal Code

_____
Defendant/Employer

_____
Mailing Address

_____
City, State, Postal Code

_____
Insurer/Self-Insured/Self-Insurance Group

_____
Insurer's Mailing Address

_____
City, State, Postal Code

_____
Additional Defendant Name

_____
Additional Defendant Mailing Address

_____
Additional Defendant City, State, Postal Code

_____
Additional Other Defendant Name

_____
Additional Other Defendant Mailing Address

_____
Additional Other Defendant City, State, Postal Code

INJURY

Date of Injury: _____

Where did injury occur:
City/State/Postal Code:

_____

Brief description of occurrence resulting in injury:

_____

Causes of Injury: _____

Body parts aff cted: _____

Nature of Injury: _____

MEDICAL INFORMATION

Medical expenses paid: $ _____ Date of last medical payment: _____

Medical expenses unpaid or contested: $ _____

Surgery performed: Yes No

Nature of Surgery: _____

Impairment ratings considered in settlement:
(Attach entire medical report that provides ratings)

Impairment		Date Given	Physician
_____	%	_____	_____
_____	%	_____	_____
_____	%	_____	_____
_____	%	_____	_____
_____	%	_____	_____
_____	%	_____	_____

Restrictions on activities:

Attach most recent medical report setting forth physical restrictions.

Diagnoses:

_____

If medical treatment is continuing, attach a copy of the executed Form 113 indicating a designated physician.

WORK INFORMATION

Does plaintiff/employee qualify for increased benefits under KRS 342.730 (1)(c)1 or 2? Yes No

Explain:

_____

☐ Yes ☐ No Has the plaintiff/employee filed for Social Security Disability or Supplemental Security Income benefits?

☐ Yes ☐ No If "No", does the plaintiff/employee intend to file for Social Security Disability or Supplemental Security Income benefits?

Type of work performed at time of injury: _____

Average Weekly Wage at time of injury: $ _____

Type of work performed after injury: _____

Wages upon returning to work: $ _____ Post-injury return-to-work date: _____

Type of work performed at time of settlement: _____

BENEFIT AND SETTLEMENT INFORMATION

Amount and duration of temporary total disability paid to date:

Beginning Date	End Date	$ per week	# of weeks	Total

For each lump sum or income benefit agreed to, show your calculation below:

Type				
Responsible party				
Frequency of payments				
Start Date				
Weekly payment rate				
Impairment Rating				
Grid Factor				
Multiplier				
Payment amount				
Number of Weeks (for income benefits)				
Present Value (for lump sums)				
Total				

Total of Lump Sum and Income Benefits: _____

Are the following waivers included in the monetary settlement?

			Amount for Waiver(s)
Waiver or buyout of past medical benefits	☐ Yes	☐ No	$ _____
Waiver or buyout of future medical benefits	☐ Yes	☐ No	$ _____
(if yes, attach most current medical report or office note from treating physical)			
Waiver of vocational rehabilitation	☐ Yes	☐ No	$ _____
Waiver of right to reopen	Yes	No	$ _____

Total of Waivers: _____

Monetary terms of settlement:

Beginning Date	Payment Amount	Frequency	# of Payments	Total Value
			Total Settlement	

If settlement terms provide for a lump sum representing weekly benefits greater than $100, does claimant have an adequate source of income during disability ☐ Yes ☐ No

Source of income: _____

Weekly amount: $_____

OTHER INFORMATION

If additional information is pertinent to the settlement, please explain (additional information may be attached to this form if required):

_____

Other responsible parties against whom further proceedings are reserved:

_____

–

If waiving medical benefits, please acknowledge by signing below:

I understand that my health insurance may not cover any medical expenses for my injury and I may be held responsible for payment of medical expenses for my injury. I further state I understand and have been advised medical benefits pursuant to the Kentucky Workers' Compensation Act are payable for the cure and/or relief of the effects of the injury without limitation as to time. I have not been promised that any entity will automatically pay for medical expenses related to my injury. I have conferred with my treating physician about medical treatment I may require in the future and I am satisfied that the amount being paid for the waiver of future medical benefits is adequate to provide for that treatment.

_____
Plaintiff/Employee Signature

If not represented by an Attorney, please acknowledge by signing below:

I understand that I have a right to obtain an Attorney of my choice to review this Agreement and by signing below I acknowledge that I have waived that right. By waiving that right, I understand I will be held to the same standard as an Attorney and this Agreement will be enforceable as if represented by Attorney.

_____
Plaintiff/Employee Signature

_____ Attorney for Plaintiff/Employee Signature	_____ Plaintiff/Employee Signature
_____ Attorney for Plaintiff/Employee Name typed	_____ Attorney for Defendant/Employer Signature
_____ Mailing Address	_____ Mailing Address
_____ City, State, Postal Code	_____ City, State, Postal Code
_____ Telephone Number	_____ Telephone Number

Other Participating Parties:

_____	_____
_____	_____
_____	_____