FORM 110
Hearing Loss/Occupational Disease/CWP
October 2016 Edition

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

AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT

Workers' Compensation Claim No.____________________
Before ________________________________

IF THIS FORM IS NOT PROPERLY COMPLETED, IT WILL BE RETURNED.
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 Street 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

HEARING LOSS OR OCCUPATIONAL DISEASE

Occupational disease: ____________________ Injury Type:

Body parts affected: ____________________

Cause of disease: ____________________

Brief description of history of exposure:

____

Length of exposure: ____________________ Date of last exposure:

Where did exposure occur:

City/State/Postal Code:

____

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:

____

Pulmonary function studies considered in settlement:
(Attach entire medical report that provides ratings)

FVC	FEV1	Date of Study	Physician
_____	_____	_______________	____________________________
_____	_____	_______________	____________________________
_____	_____	_______________	____________________________

Diagnosis:

____

ILO Classification	Date of Report	Physician
_______________	____________	________________________________
_______________	____________	________________________________
_______________	____________	________________________________
_______________	____________	________________________________
_______________	____________	________________________________

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:

____

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?
☐ Yes ☐ No

Type of work performed at last exposure: ____

Average Weekly Wage at last exposure: $ _____________

Type of work performed after return to work: ____

Wages upon returning to work: $ _____________ 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 weekly income benefit payment 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 $ ______________

Monetary terms of settlement:

Beginning Date (for periodic payments only)	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: $______________

Does settlement include retraining incentive benefits? ☐ Yes ☐ No

If yes, is claimant actively participating in instruction or training program? ☐ Yes ☐ No

Name of instruction or training program (attach explanatory pages if necessary):

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, hearing loss, or occupational disease and I may be held responsible for payment of medical expenses. 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, hearing loss, or occupational disease without limitation as to time. I have not been promised that any entity will automatically pay for medical expenses related to my injury, hearing loss, or occupational disease. 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:

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________