

CC-JOINT PETITION

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Send original and 1 copy to the Workers' Compensation Commission

In re Claim of: (Please type or Print ALL information legibly in ink.)

Claimant's Full Name (Injured Employee)
Injured Employee's Social Security Number (LAST 5 DIGITS ONLY)
Name of Employer
Employer's Insurance Carrier, Permit # for Individual Self-Insured or Own Risk Group, Uninsured

Commission File Number
Date of Injury

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony, punishable by imprisonment, a fine or both.

JOINT PETITION SETTLEMENT

This agreement is prepared and submitted pursuant to the Administrative Workers' Compensation Act, Title 85A of the Oklahoma Statutes. By signing below, each party affirms that they have read and understand its provisions, declares under penalty of perjury that all statements are true and accurate to the best of their knowledge and belief, and understands that the agreement, if approved by the Workers' Compensation Commission, is conclusive, final and binding on all the parties involved.

BY THIS AGREEMENT, the parties settle upon and determine (check one):

[] ALL ISSUES AND MATTERS IN THE CLAIM (Settlement and Resolution of Claim With Full Release)

[] SOME, BUT NOT ALL, ISSUES AND MATTERS IN THE CLAIM — Attach appendix of all outstanding issues. The appendix is subject to approval by the Workers' Compensation Commission. It MUST accompany the CC-JOINT PETITION, and be dated and signed by all parties under penalty of perjury.

1. It is hereby agreed by and between the above named parties that the claimant alleges to have sustained a compensable accidental injury or occupational disease or illness on or about ... while in the employ of the employer, causing the following injury (describe nature of injury) ... The claimant's average weekly wage before the injury entitles the claimant to a compensation rate of \$... for Temporary Total Disability and \$... for Permanent Partial Disability.

2. A claim for compensation was filed by the claimant for the injury, or, if the claimant is not represented by an attorney, a First Report of Injury was filed according to the Commission's rules pertaining to electronic data interchange, or an Employer's First Notice of Injury (CC-Form-2) was filed by the employer for the injury, and the Workers' Compensation Commission has jurisdiction in this matter.

3. This is an agreement in which the claimant agrees to accept \$... in full and final settlement of all claims for: (describe injury) ... sustained as a result of the accident referred to above, including any claim by the claimant for past, present and future compensation for temporary total disability, temporary partial disability, permanent partial disability or permanent total disability, statutory medical treatment, physical and vocational rehabilitation benefits, or loss of wage earning capacity, as a result of any and all injuries sustained in the accident. This sum is in addition to any previous amount(s) paid to the claimant, and any amount(s) for authorized, reasonable and necessary medical and rehabilitative expenses previously incurred by the claimant due to the injury. Of said sum, \$... shall be paid for permanent partial disability(... %) to ... and \$... shall be paid for ...

4. The sum of \$... shall be deducted from this settlement and paid to the claimant's attorney pursuant to the workers' compensation laws of the state.

5. For Social Security offset purposes, and if applicable, the claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$... for permanent impairment that will affect the claimant for the rest of the claimant's life. The claimant's remaining life expectancy is ... months. Therefore, even though paid in a lump sum, claimant's benefit (after deduction of attorney fees and expenses) shall be considered to be \$... a month for ... months, beginning ...

6. The respondent agrees to pay all costs, taxes and assessments, as follows: \$140.00 to the Workers' Compensation Commission prescribed by 85A O.S. § 118, unless previously paid; the Special Occupational Health and Safety Tax prescribed by 40 O.S. § 418(1), representing three-fourths of one percent (0.75%) of the joint petition settlement amount, excluding medical payments and temporary total disability compensation; if a Commission approved OWN RISK employer or group self-insurance association, the Workers' Compensation Fund assessment prescribed by 85A O.S. § 122(B)(2) representing 2% of the joint petition settlement amount pertaining to permanent total disability, permanent partial disability, and death benefits; and, in addition to other amounts, if UNINSURED, a Multiple Injury Trust Fund assessment prescribed by 85A O.S. § 31(A)(6), representing 5% of the joint petition settlement amount. For injuries occurring on or after 7/1/19: CLAIMANT agrees to pay taxes and assessments as follows: Multiple Injury Trust Fund assessment prescribed by 85A O.S. § 31(A)(7) (b), representing three percent (3%) of the joint petition settlement amount attributable to permanent partial disability or permanent total disability, shall be deducted from the settlement amount and paid by the employer.

The following spaces for calculation are for informational purposes only. In the event of any miscalculation entered in these spaces, the statutory amounts set specified in paragraph 6 shall control, and no corrected Joint Petition Settlement form need be re-processed.

OSHA Tax:
OWN RISK Tax:
MITF Tax (Uninsured):
MITF Tax (Claimant):

Administrative Workers' Compensation Act, 85A O.S. § 6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment... shall be guilty of a felony."

CLAIMANT NAME — PLEASE PRINT
CLAIMANT ADDRESS
CLAIMANT—SIGNATURE DATE
NAME OF CLAIMANT ATTORNEY, if any — PLEASE PRINT OBA #
CLAIMANT ATTORNEY — SIGNATURE DATE

EMPLOYER NAME— PLEASE PRINT
NAME OF EMPLOYER/CARRIER'S ATTORNEY — PLEASE PRINT OBA#
NAME OF EMPLOYER'S CARRIER OR OWN RISK GROUP — PLEASE PRINT
EMPLOYER/CARRIER ATTORNEY — SIGNATURE DATE

ORDER APPROVING JOINT PETITION SETTLEMENT: The Workers' Compensation Commission, having reviewed the evidence, files and records in this matter and being fully advised in the premises, approves the above Joint Petition Settlement, including attorney fees, if any, and the attached appendix to the Joint Petition Settlement, if any, which Joint Petition Settlement and appendix are incorporated herein by reference and made a part hereof. If a child support lien were filed in this workers' compensation case, the employer/carrier shall include the name of the person or government agency asserting the lien on any check for temporary total disability, permanent partial disability or permanent total disability. The employer/carrier shall comply with this order within twenty (20) days from the file stamped date of the order. In that event, and if the Joint Petition Settlement determined all issues and matters in the claim, this cause shall be fully and finally closed and resolved, and the Commission divested of further jurisdiction therein.

DONE this ... day of ...

Reporter's Initials
A copy hereof was mailed by United States regular mail on this file-stamped date to all attorneys of record and unrepresented parties.

BY ORDER OF ADMINISTRATIVE LAW JUDGE