


Settlement Documents



By Gregory P. Fletcher
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WHEN TO SETTLE BY COMPROMISE AND RELEASE:

1. When off risk
2. When wish to settle future medical
3. When claim or right to benes is disputed

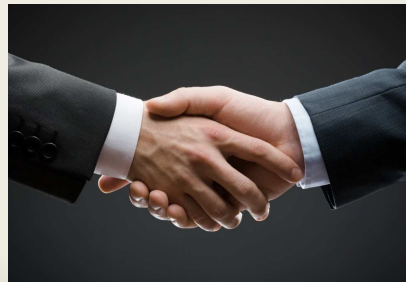


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Advantages of C&R:

- Resolves all issues (generally)
- No right to reopen
- Issues [such as penalties] resolved without admission of fault or liability



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WHEN NOT TO SETTLE BY COMPROMISE AND RELEASE:

1. Still on risk (C&R may duplicate settlement of future claims);
2. When a party is unwilling to settle future medical care (e.g., applicant concerned about ability to pay future medical, or defendant does not wish to fund MSA);
3. Other party objects (co-def; Death without Dependents Unit).



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BENEFITS WHICH CAN BE SETTLED BY COMPROMISE AND RELEASE (C&R):

1. TTD;
2. TPD (wage loss);
3. PD;
4. Life pension;
5. Future medical treatment;
6. Out of pocket medical expenses;
7. Penalties;
8. Interest on delayed payments;
9. VR, (under some circumstances; not applicable any more);
10. Supplemental job displacement benefits (voucher) for injuries prior to 1/1/13.



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WHAT CAN'T BE SETTLED BY C&R?


1. Claims over which WCAB has no jurisdiction:
 - Civil claims
 - FEHA
 - ADA
 - Retirement issues

(Third party C&R settles WC claim in connection with civil third party settlement.)
2. "Unknown" claims;
3. VR/SJDB (voucher)
 - Settlement of VR prohibited, unless "good faith" issue could defeat applicant's claim. *Thomas v. Sports Chalet* (1977) 42 CCC 625
 - Statutory prohibition against settlement of voucher for injuries on or after 1/1/13. LC 4658.7(g)



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“Thomas” for voucher in 1/1/13 case?

“Work-around” for statutory prohibition against settlement of voucher post 1/1/13?

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WHEN SHOULD YOU FIRST THINK ABOUT SETTLEMENT OF A CLAIM?

When injured worker is P&S or MMI?
For all body parts?

Not necessarily...

When claim is denied? (“Nuisance value?”)

1. Consider SETTLEMENT AT EVERY STAGE IN CLAIMS HANDLING. If you don’t, you may miss settlement opportunities.
2. HURDLES to SETTLEMENT:
 - Injured worker/applicant’s attorney;
 - WCAB (judge, I&A officer)

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“A Compromise and Release is less about the numbers, and more about who wants it more.”

Fletcher’s Rule

Can’t be forced to settle by C&R.
Always by agreement of parties.

Valuing cases and negotiation of are an art, outside the scope of this seminar. Each party must determine if settlement is cost-effective in light of risk of proceeding to trial.

Identify areas of agreement, and areas of dispute. Weigh arguments of each party in areas of dispute to determine appropriate compromise of issues in dispute.



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ALL SETTLEMENT MUST BE APPROVED BY A WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE. LC 5001

- Board Rule 10882 directs the Appeals Board to “inquire into adequacy” of C&R.



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Q: Does this mean the injured worker gets every benefit possible under the record developed by the parties?

A: NO! The settlement must only be within the range of potential outcomes.

See Board Rule 10870:

“agreements which provide for the payment of less than the full amount of compensation due or to become due, and which undertake to release the employer from all future liability will be approved only where it appears that a reasonable doubt exists as to the rights of the parties, or that approval is in the best interests of the parties.”



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TOOLS USED BY WORKERS' COMPENSATION ADMINISTRATIVE LAW JUDGE TO ASSESS ADEQUACY:

1. DEU (Disability Evaluation Unit);
2. I&A (Information and Assistance Officer)



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CLAIMS EXAMINER'S BEST TOOLS TO ESTABLISH ADEQUACY OF SETTLEMENT:

- Superior skill in drafting C&R;
- Providing supporting documents;
- Explaining basis of settlement.



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UPON SUBMISSION OF SETTLEMENT JUDGE CAN:

1. Approve it;
2. Suspend and make inquiries re basis of settlement or missing documents;
3. Set hearing on adequacy; or
4. Disapprove settlement

The Judge CANNOT make unilateral changes to settlement documents.
Burbank Studios v. WCAB (Yount), (1982) 47 CCC 832; Hodgeman v WCAB, (2007) 72 CCC 1202.

Each party represents that it has carefully read and understood the entire contents of a copy hereof. Each party's attention is directed to the fact that by entering into this Agreement on behalf of its signature below.

<p>COMPANY</p> <p>By: _____</p> <p>Name: _____</p> <p>Title: _____</p> <p>Date: _____</p>	<p>COSTUMER</p> <p>By: _____</p> <p>Name: _____</p> <p>Title: _____</p> <p>Date: _____</p>
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THE FORM:

DWC – CA FORM 10214(c) (The regulation which provides the form to the public). Required contents are provided in LC 5003-5004.

2 other forms not discussed in this seminar:

- a. Death & Dependency Claim
- b. Third Party Compromise and Release.

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PAGE ONE-


- Include all case #'s
- Applicant's SS #
- VENUE – usually based on AA's office or applicant's residence
- Let applicant or attorney fill in applicant's address (so no future argument that check was sent to wrong address)
- Provide ER name and address: be accurate insurance info. You can be sanctioned for mistakenly identifying ER as "self-insured."

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Coldiron v. Compuware (2002) 67 CCC 289

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**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE**



[Include all cases settled](#)

Case Number 1 _____

Case Number 2 _____

Case Number 3 _____

Case Number 4 _____

Case Number 5 _____

Applicant's SS# _____

SSN (Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

VENUE

Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee (Completion of this section is required)

First Name _____ MI _____

Last Name _____

LEAVE ADDRESS BLANK FOR APPLICANT TO FILL OUT

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer Information (Completion of this section is required)

Insured Self-Insured Legally Uninsured Uninsured

BE ACCURATE REGARDING ER'S INSURANCE SITUATION

Employer Name (Please leave blank spaces between numbers, names or words) _____

OR RISK SANCTIONS

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

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THE FORM - PAGE 2

- AA and DA info. If no AA or DA, leave blank

- Insurance Company – Note next page is Claims Administrator. If intention is to identify TPA, put it on next page.



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Applicant's Attorney or Authorized Representative:
 Law Firm/Attorney Non Attorney Representative
LEAVE ADDRESS BLANK IF NO AA
 First Name _____
 Last Name _____
 Law Firm Number _____
 Law Firm Name _____
 Address/PO Box (Please leave blank spaces between numbers, names or words) _____
 City _____ State _____ Zip Code _____

Defendant's Attorney or Authorized Representative:
 Law Firm/Attorney Non Attorney Representative
LEAVE ADDRESS BLANK IF NO DA
 First Name _____
 Last Name _____
 Law Firm Number _____
 Law Firm Name _____
 Address/PO Box (Please leave blank spaces between numbers, names or words) _____
 City _____ State _____ Zip Code _____

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administrator)
DISTINGUISH FROM TPA (NEXT PAGE)
 Insurance Carrier Name (Please leave blank spaces between numbers, names or words) _____
 Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____
 City _____ State _____ Zip Code _____

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THE FORM – PAGE 3

- Distinguish between TPA and Ins. Co. (I usually use the same PO Box for Ins. Co. that I have for TPA. Have never had a problem with this.)

CLAIM INFORMATION:

- DOB – Check EAMS to be sure the info in your C&R is consistent. Sometimes EAMS info needs to be corrected.
- OCCUPATION – OK to put “in dispute” but need to explain. Better to put in most accurate occupation. (Try to support assertion that C&R is “award” of specific PD rating for purposes of future apportionment.)

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Claims Administrator Information (if known and if applicable)

TPA
Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City State Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born **CHECK EAMS**, alleges that while employed as a(n) **+**
(DATE OF BIRTH: MM/DD/YYYY)

"IN DISPUTE", OCC FROM YOUR RATING, OR BY AGMT, sustained injury
(OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations and during the dates listed below:
(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

Specific Injury

Case Number 1: **ADJXXXXX1** Cumulative Injury **04/01/2014** (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: **100 HEAD** Body Part 2: **540 TOES** Body Part 3: **420 BACK**

Body Part 4: **318 ARM** Other Body Parts: **842 NERVOUS SYSTEM - PSYCHIATRIC/PSYCH**

The injury occurred at **[JOB SITE - IF KNOWN]** **PSYCHIATRIC/PSYCH**
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

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Specific Injury

Case Number 2: **ADJXXXXX2** Cumulative Injury **04/02/2013** **04/02/2014** (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: **145 TEETH** Body Part 2: **110 BRAIN** Body Part 3: **140 FACE**

Body Part 4: **320 WRIST** Other Body Parts: **840 NERVOUS SYSTEM - STRESS**

The injury occurred at **111 NORMAL STREET**
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

ANYTOWN **CA** **90000**
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 3: Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 4: Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: Body Part 2: Body Part 3:

Body Part 4: Other Body Parts:

The injury occurred at
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

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BODY PART CODES LIST

100 Head - not specified
 110 Brain
 120 Ear - not specified
 121 Ear - external
 124 Ear - internal including hearing
 130 Eye - including optic nerves and vision
 140 Face - not specified
 141 Jaw - including chin and mandible
 144 Mouth - including lips, tongue, throat and larynx
 145 Teeth
 146 Nose - including nasal passages, sinus and smell
 148 Face - multiple parts any combination of above parts
 149 Face - forehead, cheeks, eyelids
 150 Scalp
 160 Skull
 198 Head - multiple injury any combination of above parts
 200 Neck
 300 Upper extremities - not specified
 310 Arm - above wrist not specified
 311 Arm - upper arm humerus
 313 Arm - elbow head of radius
 315 Arm - forearm radius and ulna
 318 Arm - multiple parts any combination of above parts
 319 Arm - not specified
 320 Wrist
 330 Hand - not wrist or fingers
 340 Fingers
 398 Upper extremities - multiple parts any combination of above parts
 400 Trunk - not specified
 410 Abdomen - including internal organs and groin
 411 Hernia
 420 Back - including back muscles, spine and spinal cord
 430 Chest - including ribs, breast bone and internal organs of the chest
 440 Hips - including pelvis, pelvic organs, tailbone, coccyx and buttocks
 450 Shoulders - scapula and clavicle
 498 Trunk - use for side, multiple parts any combination of above parts
 500 Lower extremities - not specified
 510 Legs - above ankles, not specified
 511 Thigh femur
 513 Knee Patella
 515 Lower leg tibia and fibula

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518 Leg - multiple parts any combination of above parts
 519 Leg - not specified
 520 Ankle malleolus
 530 Foot not ankle or toe
 540 Toes
 598 Lower extremities - multiple parts any combination of above parts
 700 Multiple parts more than five major parts use only in fifth position of listing of body parts
 800 Body system - not specific
 801 Circulatory system - Heart - other than heart attack, blood, arteries, veins, etc.
 802 Circulatory system - Heart attack
 810 Digestive system - stomach
 820 Excretory system - kidneys, bladder, intestines, etc.
 830 Musculo-skeletal system - bones, joints, tendons, muscles, etc.
 840 Nervous system - not specified
 841 Nervous system - Stress
 842 Nervous system - Psychiatric/psych
 850 Respiratory system - Lungs, trachea, etc.
 860 Skin dermatitis, etc.
 870 Reproductive systems
 880 Other body systems
 999 Unclassified - insufficient information to identify body parts

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THE FORM – PAGE 3 cont'd

- CLAIM INFORMATION: Applies to all claims with ADJ#'s.
- SPECIFIC INJURY: Use "state date"
- CUMULATIVE TRAUMA: Start and end dates.



Q: Stick to 1 year CT period?

A: Customary, but not necessary.

What were allegations? If only end date alleged, generally provide start date 1 year earlier.



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THE FORM – PAGE 3 cont'd

BODY PARTS: Use EAMS codes. Include every injured body part alleged, or you may not have settled that part of the claim!

ISSUE: EAMS does not specify right or left extremity, only "arm", "leg", or "wrist." Clarify in comment section if any ambiguity.

The electronic form does not provide enough characters to provide the entire description in the EAMS body codes. Clarify in comment section if needed.



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THE FORM – PAGE 5 – PAYMENTS MADE

- Provide AWW for “earnings”. If in dispute, so indicate and describe resolution of dispute in comments section. If dispute resolved via compromise AWW, list that as the AWW.
- Provide payments of TTD, PD and medical expenses in lines provided. Should conform to the printout of benefits. If multiple periods, 3 options:
 1. List all periods in comments section;
 2. List first period in spaces allotted on form and additional period(s) in comments section;
 3. Put first and last date of payment on form and indicate in comments section that payments were made during “broken periods” or “various periods.”



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THE FORM – PAGE 5 – PAYMENTS MADE

EXAMPLES:

- “TTD paid 01/01/2012 through 04/01/2012 at a rate of \$400 per week; 01/01/2013 through 06/01/2013 at rate of \$400 per week.”
- “TTD paid in broken periods.”
- “PD paid in lump sum in amount of \$5,000.00 04/01/2013.”
- “TD paid as wage loss at varying rates 01/01/2012 through 06/01/2012.”

MEDICAL PAYMENTS: Provide total payments for medical treatment. Not include medical-legal costs or medical management costs (nurse case manager; bill review). This item rarely questioned.



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Specific Injury

Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

Case Number 5 _____

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City _____ State _____ Zip Code _____

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY \$ [AWW] _____

TEMPORARY DISABILITY INDEMNITY PAID [TOTAL] _____ Weekly Rate \$ [RATE] _____

Period(s) Paid _____ (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID [TOTAL] _____ Weekly Rate \$ [RATE] _____

Period(s) Paid _____ (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID \$ TOTAL MED TREATMENT _____ Total Unpaid Medical Expense to be Paid By: PER P 8 _____

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

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UNPAID MEDICAL EXPENSES:

- If claim denied, or in nuisance settlement, indicate medical bills to be paid by "applicant." Judge may question this!
- In most cases, put "per paragraph 8 [liens] below." EAMS will only allow a few characters, so it is compressed to: "per p 8."
- Explanation can be included on page 6, para 8.
- Note resolution of all liens. Generally EDD rep signs C&R noting settlement agreement.
- Resolutions of liens can be in separate Stip and Orders, typically approved by WCJ. Informal agreements can be noted in C&R. Confirmation letters can be retained to show judge.



7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

\$ **GROSS AMOUNT**

Settlement Amount

The following amounts are to be deducted from the settlement amount:

\$ **TOTAL PDA'S** for permanent disability advances through **DATE OF PRINTOUT**

\$ **EXPLAIN!** for temporary disability indemnity overpayment, if any.

\$ payable to **CHILD SUPPORT (DOCUMENT RESOLUTION)**

\$ payable to **LIEN FOR LIVING EXPENSES**

\$ payable to **EDD (?)**

\$ payable to **MSA (?)**

\$ **LEAVE FOR ATTY** requested as applicant's attorney's fee.

LEAVING A BALANCE OF \$ **NET TO APPLICANT**, after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

EDD HAS AGREED TO ACCEPT _____ AS FULL AND FINAL SATISFACTION OF ITS LIEN IN THE AMOUNT OF \$ _____, FOR PERIOD(S) _____ THROUGH _____.
[GET EDD REP SIGNATURE]

THE LIENS OF DR. X, HOSPITAL Y, AND HEALTHCARE PROVIDER Z HAVE BEEN RESOLVED. [BE READY TO PROVIDE DOCUMENTATION OF AGREEMENTS.]

DEFENDANT(S) AGREE TO PAY, ADJUST OR LITIGATE ALL UNPAID BILLS AND LIENS FOR MEDICAL TREATMENT THROUGH THE DATE OF APPROVAL OF THIS COMPROMISE AND RELEASE.
[AVOID "HOLD HARMLESS" LANGUAGE!]

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Ok TO AGREE TO PAY, ADJUST OR LITIGATE ANY LIENS. But AVOID holding applicant harmless.

EDD: Best practice resolve lien prior to negotiating C&R. Reason: some reimbursement to EDD might need to be deducted from settlement.

MEDICAL TREATMENT: If applicant held harmless, def can only assert defenses available to applicant. For example, def can no longer argue treatment was outside the MPN.

Barajas v. F&H Cold Storage (2010) ADJ6559495 (WCAB Panel Decision)



C&R FORM – PAGE 6, PARAGRAPH 7

- Start with GROSS AMOUNT of settlement, then work through deductions.
- PDAs: use most current printout and provide total. Include PD paid out on all claims being settled. Provide date of calculation of PDAs (typically date of printout).
- Form provides credit for any PD paid after the date given in paragraph 7.

IF AMOUNT OF PDAs ON FORM IS
INCORRECT DEFENDANT WILL PROBABLY
LOSE CREDIT FOR AMOUNT NOT
INCLUDED!

*County of San Joaquin v. WCAB (Oaks), 76 CCC 169
(Writ Denied – 2011)*

Q: “Subject to proof”? Will this protect
defendant?



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C&R FORM – PAGE 6, PARAGRAPH 7, cont'd

- TD OVERPAYMENTS – Form provides for deduction for TD overpayments, but DON'T BE FOOLED! This does not automatically mean the judge will allow it. Be sure injured worker or attorney is aware of the claimed overpayment and agrees to credit. EXPLAIN basis for credit in COMMENTS section of C&R.
- If credit is due to an error by claims examiner, WCAB may not allow credit even if agreed upon by parties.
- *J.C. Penney* case: overpayment was due to retroactive P&S date by AME. Payment based on PTP. Credit NOT allowed for overpayment because no objection per LC 4062 to issue of TTD status!



J.C. Penney v. WCAB (2009) 74 CCC 826

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C&R FORM – PAGE 6, PARAGRAPH 7, cont'd

- Other deductions may include liens for child support or liens for living expenses. These are typically settled by applicant, but deducted from settlement. Be sure judge is provided sufficient documentation of agreement with lien claimant to be satisfied lien is resolved.
- If settlement of EDD lien includes payment by applicant, this is the place to note the deduction from the settlement.
- ATTORNEY FEE – Leave blank for applicant's attorney to fill out. Or if applicant unrepresented, leave blank, but fill in balance owed to applicant.

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C&R FORM – PAGE 6, PARAGRAPH 7, cont'd



Q: Include deduction for MSA?

A: Depends on how MSA is being handled in settlement. If actual trust is being created, probably deduct amount going into trust.

If applicant is self-administering MSA, probably best to rely solely on language in COMMENTS or separate MSA addendum.

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9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

Applicant	Defendant
<input type="checkbox"/>	earnings
<input checked="" type="checkbox"/> GPF	temporary disability
<input type="checkbox"/>	jurisdiction
<input checked="" type="checkbox"/> GPF	apportionment
<input type="checkbox"/>	employment
<input type="checkbox"/>	injury AOE/COE
<input type="checkbox"/>	serious and willful misconduct
<input type="checkbox"/>	discrimination (Labor Code §132a)
<input type="checkbox"/>	statute of limitations
<input checked="" type="checkbox"/> GPF	future medical treatment
<input type="checkbox"/>	other _____
<input checked="" type="checkbox"/> GPF	permanent disability _____
<input checked="" type="checkbox"/> GPF	self-procured medical treatment, except as provided in Paragraph 7
<input checked="" type="checkbox"/> GPF	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

THIS SETTLEMENT IS BASED ON THE PANEL QME REPORT OF DR. PHIBES, RATED BY THE DEU AT 10% PD (\$8,772.50).

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

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C&R FORM – PAGE 7

BOTH PARTIES MUST INITIAL ALL ISSUES BEING SETTLED. IF YOU DON'T IDENTIFY AN ISSUE AS SETTLED, YOU HAVEN'T SETTLED IT!

Tobar Industries v WCAB (Phan), 77 CCC 300 (Writ Denied – 2012)

C&R had ADDENDUM indicating LC 132a Petition was being settled, but the “discrimination (Labor Code §132a)” issue was not initialed. WCAB held 132a Petition was NOT settled by C&R!





Q: Initial every box? This is common practice, but some judges will then inquire regarding the nature of the dispute and want to know that the C&R contains consideration for resolving the dispute.

Best Practice: Only initial issues actually being resolved.

BE SURE TO HAVE APPLICANT OR ATTORNEY INITIAL ISSUES!



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C&R FORM – PAGE 7 cont'd

COMMENTS:

Your opportunity to explain basis for settlement and clarify any points not clear in rest of settlement documents.

Don't worry if explanation doesn't fit the box. Put the extra comment in Addendum. Note "Addendum A is incorporated into this agreement." Judges don't like boiler-plate addenda that attempt to over-reach. They do appreciate simple explanations of what is being settled and WHY IT IS ADEQUATE.

Recite basis for settlement of PD. Consider providing rating string. Whenever possible give % of PD being settled. Give dollar value. (Make it EASY for judge to evaluate settlement).



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C&R FORM – PAGE 7 cont'd

COMMENTS, cont'd:



Q: Will % of PD be sufficient for LC 4664 apportionment in future claims?

A: Unknown. We only know that an Order Approving C&R without more is not an "Award" for purposes of LC 4664 apportionment.

Pasquotto v. Hayward Lumber (2006) 71 CCC 223

Why not try? If it becomes common practice we may see a trend of cases allowing apportionment to earlier C&R. (But watch for whether PD is really for same body parts.)

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C&R FORM – PAGE 7 cont'd



Q: What about a denied claim?

Can still use "*Thomas*" language identifying issue which could defeat applicant's claim. Make "offer of proof" identifying evidence and witnesses and what defense evidence would show.

Thomas v. Sport Chalet (1977) 42 CCC 625

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For Example:

“The WCAB could find of no injury based on testimony of employer witnesses Pat Sajak and Vanna White, who will testify applicant said injured himself at home jumping up and down in front of television.”

Thomas was about settling voc rehab which no longer exists, so no need to ask for a “*Thomas*” finding.

But explanation can justify settlements at “nuisance” value, and can be used to negotiate with lien claimants.

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Q: What if applicant is not yet permanent and stationary (P&S) or at Maximum Medical Improvement (MMI)?

A: Use language that justifies the settlement;

- Estimate level of PD (difficult);
- “*Thomas*” type language (if facts justify it);
- or “Applicant does not wish to participate in discovery” (deposition or med-legal eval).

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SAMPLE

Case Name _____ ADJ _____

Addendum "A" to C&R

Applicant was terminated from employment with EMPLOYER for cause January 24, 2013.

She had bilateral carpal tunnel surgeries through private insurance and was temporarily totally disabled 05/14/2013 through 07/31/2013, and testified in her deposition that she was returned to work by her treating doctor on 08/31/2013.

No TTD was paid. Employer was not provided notice of surgeries or applicant's work status



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SAMPLE (cont'd)

EDD paid applicant SDI benefits 05/14/2013 through 07/31/2013 at the rate of \$269 per week. EDD's lien is resolved herein.

TTD rate would have been \$369.76 per week. This settlement includes payment to applicant for the balance owed after credit for EDD's payments for TD 05/14/2013 through 07/31/2013 in amount of \$1,238.72.

There is a dispute regarding whether LC 4658(d)(2) applies, as applicant was terminated for cause and def asserts employer should not be obligated to make an offer of work under such circumstances.

However, as part of this agreement defendants are providing a \$6,000.00 Supplemental Job Displacement Benefit (Voucher) to applicant.



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Additional Attachments:

When to include "ADDENDUM"?

- Lengthy, boilerplate addenda are disfavored. When C&R form was revised and expanded, one reason given was to eliminate need for addenda.
- This does NOT mean that addenda are prohibited. But ask whether it is necessary. Many boilerplate addenda contain provisions which will not be allowed.

Examples:

- "This agreement resolves all injuries, known or unknown."
- Settlement of civil, employment, FEHA or ADA claims.
- "This agreement settles all injuries to body parts mentioned in the medical record."



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STRUCTURED SETTLEMENT

- When using structured settlement, provide addendum outlining terms of structure. Be sure that comment section indicates payment will be made in accordance with terms of the structure.



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MSA (Medicare Set-Aside) Addendum:

Some clients require addenda setting forth requirements of applicant to self-administer MSA. For example, keeping receipts, depositing payments into MSA account, regular reporting to CMS.

Probably OK, but WCALJ will probably not approve language requiring applicant to hold def harmless if CMS increases MSA amount.

Ask if anything more is required than standard language:

“This settlement contemplates funding of a Medicare Set-Aside in the amount of _____ out of the proceeds of the settlement. Applicant agrees to administer the Medicare Set-Aside trust.”



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MSA Addendum cont'd

If settling by C&R without Medicare Set-Aside:

“Applicant represents he/she is not presently eligible for Medicare and not anticipated to become eligible for Medicare within the next 30 months. Medicare’s interests are protected in this settlement.”

If settling under CMS review threshold, simply indicate that “Medicare’s interests are protected in this settlement.” Technically, if applicant is eligible for Medicare, MSA required but submission of MSA to CMS is not required.



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BE SURE TO GET APPLICANT'S SIGNATURE
with either:

- 2 witnesses (not family members) must be “disinterested”, or
- in front of Notary Public



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11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this _____ day of _____, _____ at _____

Witness 1	(Date)	Applicant (Employee)	(Date)
Witness 2	(Date)	Attorney for Applicant	(Date)
Interpreter	(Date)	Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)
		Attorney for Defendant	(Date)

DWC-CA form 10214 (c) (Rev. 11/2008) (Page 8 of 9)

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ACKNOWLEDGMENT

State of California
County of _____)

On _____ before me, _____
(insert name and title of the officer)

personally appeared _____
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are
subscribed to the within instrument and acknowledged to me that he/she/they executed the same in
his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the
person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing
paragraph is true and correct.


WITNESS my hand and official seal.

Signature _____ (Seal)

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CHARACTERISTICS OF STIP WITH REQUEST FOR AWARD

1. Admitting injury; 
2. Medical care typically left open;
3. All payment periods and rates specified;
4. Can be reopened w/in 5 yrs from the date of injury for "new and further disability."



STIP WITH REQUEST FOR AWARD: THE FORM

- OCR form is similar to C&R form.

DIFFERENCES:

Page one requests venue information, (important when Stipulations act as Application)

Party info (injured worker, employer, carrier and TPA) is essentially the same.

Case info is also similar.


PAY SPECIAL ATTENTION TO DESCRIPTION OF INJURED BODY PARTS!

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Reset Form Print Form



**STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
STIPULATIONS WITH REQUEST FOR AWARD**

Case No. _____ Date of Injury _____ MM/DD/YYYY

SSN (Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)

County where injury occurred (Labor Code section 5501.5(a)(2) or (d).)

County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

Select 3 Letter Office Code For Place/Venue of Hearing (From the Document Cover Sheet)

Applicant (Completion of this section is required)

First Name _____ MI _____

Last Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer #1 Information (Completion of this section is required)

Insured Self-Insured Legally Uninsured Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

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Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administration) +

Insurance Carrier Name (Please leave blank spaces between numbers, names or words) _____

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Claims Administrator Information (if known and if applicable) +

Name (Please leave blank spaces between numbers, names or words) _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer #2 Information (Completion of this section is required)

Insured Self-Insured Legally Uninsured Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Insurance Carrier Identification (if known and if applicable - include even if carrier is adjusted by claims administration)

Insurance Carrier Name (Please leave blank spaces between numbers, names or words) _____

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

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Claims Administrator Information (if known and if applicable) +

Name (Please leave blank spaces between numbers, names or words) _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Employer #3 Information (Completion of this section is required)

Insured Self-Insured Legally Uninsured Uninsured

Employer Name (Please leave blank spaces between numbers, names or words) _____

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Insurance Carrier Information (if known and if applicable - include even if carrier is adjusted by claims administration) +

Insurance Carrier Name (Please leave blank spaces between numbers, names or words) _____

Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words) _____

Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

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Employer #4 Information (Completion of this section is required)			
<input type="checkbox"/> Insured	<input type="checkbox"/> Self-Insured	<input type="checkbox"/> Legally Uninsured	+
Employer Name (Please leave blank spaces between numbers, names or words) _____			
Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____			
City _____	State _____	Zip Code _____	
Insurance Carrier Information (If known and if applicable - Include even if carrier is adjusted by claims administrator)			
Insurance Carrier Name (Please leave blank spaces between numbers, names or words) _____			
Insurance Carrier Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____			
City _____	State _____	Zip Code _____	
Claims Administrator Information (If known and if applicable)			
Name (Please leave blank spaces between numbers, names or words) _____			
Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____			
City _____	State _____	Zip Code _____	
The patient's body sections to the assistance of an Award and/or Order based upon the following dates, and waive the requirements of Labor Code section 13313:			
1. _____	_____	_____	+
Employee First Name _____			
Employee Last Name _____			
Birth date _____ WMMDDYYYY _____			
while employed at _____		State _____	
as a(n) _____	Occupation _____		
		Group _____	+
		In _____	
<small>DWIC-CA form 10274 (4) Page 4 (Rev. 11/2008)</small>			

<input type="checkbox"/> More than 4 Companion Cases			
<input type="checkbox"/> Specific Injury			+
Case Number 1 _____	<input type="checkbox"/> Cumulative Injury	(Start Date: WMMDD/YYYY) (If Specific Injury, use the start date as the specific date of injury)	
Body Part 1: _____	Body Part 2: _____	Body Part 3: _____	
Body Part 4: _____	Other Body Parts: _____		
	<input type="checkbox"/> Specific Injury		
Case Number 2 _____	<input type="checkbox"/> Cumulative Injury	(Start Date: WMMDD/YYYY) (If Specific Injury, use the start date as the specific date of injury)	
Body Part 1: _____	Body Part 2: _____	Body Part 3: _____	
Body Part 4: _____	Other Body Parts: _____		
	<input type="checkbox"/> Specific Injury		
Case Number 3 _____	<input type="checkbox"/> Cumulative Injury	(Start Date: WMMDD/YYYY) (If Specific Injury, use the start date as the specific date of injury)	
Body Part 1: _____	Body Part 2: _____	Body Part 3: _____	
Body Part 4: _____	Other Body Parts: _____		
	<input type="checkbox"/> Specific Injury		
Case Number 4 _____	<input type="checkbox"/> Cumulative Injury	(Start Date: WMMDD/YYYY) (If Specific Injury, use the start date as the specific date of injury)	
Body Part 1: _____	Body Part 2: _____	Body Part 3: _____	
Body Part 4: _____	Other Body Parts: _____		
by the employer(s) and their insurer(s) listed above and who sustained injury(ies) arising out of and in the course of employment to _____			
(Please list all body parts injured)			
<small>DWIC-CA form 10274 (4) Page 5 (Rev. 11/2008)</small>			

REMEMBER:



**IN STIPULATED AWARDS
MEDICAL CARE REMAINS
OPEN FOR ALL INJURED BODY
PARTS.**

Stipulations will be construed against defense. Be as narrow in your description as possible.

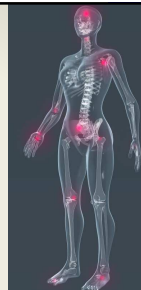
Example: “foot” instead of “lower extremity”, “low back” instead of “back” or “spine.”



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REAL EXAMPLE:



- Stipulation to “internal injuries” was construed to include fibromyalgia.
- Language in box at bottom of page 5 will control, not body part codes listed in case info.



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2. The injury (ies) caused temporary disability for the period _____ MMDDYYYY through _____ MMDDYYYY for which indemnity has been paid at \$ _____ indemnity paid _____ per week _____ through _____ MMDDYYYY at the rate of \$ _____ Rate in the amount of \$ _____ indemnity paid _____

2(a) The injury(ies) caused additional temporary disability for the period _____ MMDDYYYY through _____ MMDDYYYY in the amount of \$ _____

3. The injury(ies) caused permanent disability of _____ % for which indemnity is payable at \$ _____ temporary rate per week beginning _____ MMDDYYYY in the sum of \$ _____ less credit for such payments previously made. And a life pension of \$ _____ Life Pension less credit for such payments Labor Code §4558(d) adjustment: Increase rate to \$ _____ as of _____ MMDDYYYY Decrease rate to \$ _____ as of _____ MMDDYYYY Not Applicable _____ +

An informal rating has / has not (Select one) been previously issued in case no(s) _____.

4. There is is Not a need for medical treatment to cure or relieve from the effects of said injury (ies)

5. Medical-legal expenses and/or liens are payable by defendant as follows:

6. Applicant's attorney requests a fee of \$ _____ Fees to be commuted as follows: _____

7. Liens Against compensation are payable as follows: _____

DNIC Claim 10214 (4) Page 6 (Rev. 1/2008) _____ +

2. The injury (ies) caused temporary disability for the period _____ MMDDYYYY through _____ MMDDYYYY for which indemnity has been paid at \$ _____ indemnity paid _____ per week _____ through _____ MMDDYYYY at the rate of \$ _____ Rate in the amount of \$ _____ indemnity paid _____

2(a) The injury(ies) caused additional temporary disability for the period _____ MMDDYYYY through _____ MMDDYYYY in the amount of \$ _____

3. The injury(ies) caused permanent disability of _____ % for which indemnity is payable at \$ _____ temporary rate per week beginning _____ MMDDYYYY in the sum of \$ _____ less credit for such payments previously made. And a life pension of \$ _____ Life Pension per week hereafter: _____

An informal rating has / has not (Select one) been previously issued in case no(s) _____.

4. There is is Not a need for medical treatment to cure or relieve from the effects of said injury (ies)

5. Medical-legal expenses and/or liens are payable by defendant as follows: _____

6. Applicant's attorney requests a fee of \$ _____ Fees to be commuted as follows: _____

7. Liens Against compensation are payable as follows: _____

DNIC Claim 10214 (4) Page 6 (Rev. 4/2014) _____ +

NOTE: 2 DIFFERENT FORMS FOR INJURIES BEFORE & AFTER JAN 1, 2013

- Reason: 15% increase or decrease in PD rate for failure to offer mod work no longer applies to DOI o/a 1/1/13.

Pre – 1/1/13:

1. Determine if employer has 50 or more employees;
2. Check for offer of modified work w/in 60 days of P&S;
3. Increase remaining PD payment by 15%

NOTE: WATCH FOR PDA's! Most money charts assume no PDA's prior to P&S date.



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NOTE:

- Stipulations form provides for 2 periods of TD payments (more flexible than C&R form).

NOTE:

- Provision for LIFE PENSION in PD section of Stipulations form.

Q: Is there need for medical treatment (paragraph 4)?

- In 99.99999% of cases the answer will be yes, and box should be checked indicating there is need for medical care.
- Even if QME finds no need for medical care, WCAB will not approve Stips indicating no need for medical care if treatment records contain any possibility of future treatment.



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Question...

Can you limit Future Medical Care to treatment recommended by AME or QME? No, in Northern California. Maybe, in Southern California.

BUT

BE CAREFUL WHAT YOU WISH FOR:

Bertrand v. City of Orange (2014), ADJ3135829, Board Panel Decision held that 2004 Stipulations with Request for Award in which medical treatment “disputes” were to be decided by AME as a WAIVER of the IMR process.



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LIENS:

- Form distinguishes between Medical-Legal liens and liens against compensation.

MED-LEGAL:

“All paid or will be paid per the medical-legal fee schedule.”

LIENS AGAINST COMPENSATION:

- Medical treatment: use same “pay, adjust or litigate language” as C&R.

True liens against compensation:

- Living expenses
- Child support
- (possibly EDD)



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8. Any accrued claims for Labor Code section 501.4 penalties are included in this settlement unless expressly excluded.
9. Other stipulations:

+

Called _____ M/M/DD/YYYY _____ Applicant _____

Law Firm/Attorney Non Attorney/Representative +

First Name _____

Last Name _____

Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Called _____ M/M/DD/YYYY _____ Applicant Attorney Signature _____

DWCC-CA Item 10214 (a) Page 7 (Rev 11/2008) +

Defendant's Attorney or Authorized Representative:
 Law Firm/Attorney Non Attorney/Representative +

First Name _____

Last Name _____

Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Called _____ M/M/DD/YYYY _____ Defense Attorney Signature _____

Defendant's Attorney or Authorized Representative:
 Law Firm/Attorney Non Attorney/Representative

First Name _____

Last Name _____

Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Called _____ M/M/DD/YYYY _____ Defense Attorney Signature _____

DWCC-CA Item 10214 (a) Page 8 (Rev 11/2008) +

Defendant's Attorney or Authorized Representative:
 Law Firm/Attorney Non Attorney Representative

First Name _____

Last Name _____

Firm Number _____

Law Firm Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ State _____ Zip Code _____

Dated _____ MM/DD/YYYY _____ Defense Attorney Signature _____

Interpreter Licence Number:

Interpreter Name _____ Interpreter Licence Number _____

+ +

+ +

DWC-CA form 10214 (a) Page 9 (Rev 11/2008)

OTHER STIPULATIONS

- Use to explain basis of settlement.
Focus on PD: medical report(s);
provide rating and dollar value.

INTEREST:

- Include the following in ALL Stipulations requiring payment:
- "Interest is waived if payment is made within 30 days of the service of the Award pursuant to these Stipulations."

SIGNATURES:

- No need for applicant to sign in front of witnesses or notary public.



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Labor Code Section 5814(c)

“Upon the approval of a compromise and release, findings and award, or stipulations and orders by the appeals board, it shall be conclusively presumed that any accrued claims for penalty have been resolved, regardless of whether a petition for penalty has been filed, unless the claim for penalty is expressly excluded by the terms of the order or award.”

If the potential claim for penalty for unreasonable delay in any benefits being settled, the penalty issue must be expressly deferred or it will be deemed resolved.

“All other issues are deferred” will probably not be good enough to preserve claim of penalty!



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WHAT TO INCLUDE WITH C&R WHEN SUBMITTED (PRO-PER SETTLEMENT):

1. All benefits notices as required by Rule 9812;
2. Copy of PTP P&S report;
3. Info about who objected to PTP, if anyone, and why;
4. Notice of right to QME, as req'd by Rule 9812;
5. Copies of all AME/QME reports;
6. All wage documentation and calculations to determine TD and PD;
7. Info that the injured worker was given a choice and explanation of Stip vs. C&R;
8. Copies of all available DEU ratings;
9. Proofs of Service that all proposed settlement and medical records have been served on all lien claimants;
10. All letters providing notice of potential eligibility for supplemental job displacement benefits per Labor Code §4658; and
11. Fully completed settlement documents.



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WHAT TO INCLUDE WITH C&R WHEN SUBMITTED (PRO-PER) cont'd

NOT NECESSARILY REQUIRED IN EVERY
CASE.

All that is required are:

- executed (signed & initialed) settlement doc
- supporting med report
- proof of service on lien claimants
- other supporting documents, i.e., if less than max earner, provide wage statement

CONSIDER COVER LETTER WITH C&R
PACKAGE OUTLINING BASIS FOR
SETTLEMENT



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What to do when you get an Order Suspending Action on C&R?

DON'T PANIC!!



It is not disapproving the C&R

Read it carefully and RESPOND:

- Answer Judge's questions;
- Provide requested documents



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