Reset Form Print Form

STATE OF CALIFORNIA
DIVISION OF WORKERS' COMPENSATION
WORKERS' COMPENSATION APPEALS BOARD
COMPROMISE AND RELEASE
(Dependency claim)

Case Number 1

Case Number 4

Case Number 2

Case Number 5

Case Number 3

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 Document Cover Sheet)

Employee (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 (Completion of this section is required)

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

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

1. The below - named dependent(s) claims that _____
(NAME OF EMPLOYEE)

while employed at _____ on _____ by
Date of Injury: MM/DD/YYYY

_____ , then insured as to worker's compensation
(NAME OF EMPLOYER)

liability by _____
(STATE NAME OF CARRIER OR WHETHER SELF - INSURED)

sustained injury arising out of and in the course of such employment as follows:

2. The death of the said employee occurred on _____ , as a result of the claimed injury.
Date of Employee Death: MM/DD/YYYY

3. The actual weekly wages of the employee at the time of claimed injury were, _____ , while average weekly wages (statutory) were _____ .

4. Payments of compensation to the employee in his lifetime on the account of the claimed injury were _____ .

5. The applicant(s) herein claims to have been dependent upon said employee at the time of the claimed injury and states the name(s), age(s), relationship to, and the extent of dependency upon the deceased employee to have been as follows:

Dependent # 1 of Employee

First Name _____ MI _____

Last Name _____

Age _____ Relationship _____ Extent of dependency ☐ Partial ☐ Total

Dependent # 2 of Employee

First Name _____ MI _____

Last Name _____

Age _____ Relationship _____ Extent of dependency ☐ Partial ☐ Total

Dependent # 3 of Employee

First Name _____ MI _____

Last Name _____

Age _____ Relationship _____ Extent of dependency ☐ Partial ☐ Total

6. The parties hereby agree to settle any and all claims of said dependent(s) on account of the claimed injury and the death of said employee by the payment of sum of $ _____ , payable as follows to:

7. The parties hereby agree (if such items of expense be claimed) that medical, hospital and burial expense required by reason of alleged injury and death of employee shall be borne as follows:

8. Is the Applicant Represented?: ☐ Yes ☐ No **if "No", applicant is to sign and date below.**
if "Yes", applicant's representative is to complete the following and is to sign and date below.

☐ Law Firm/Attorney ☐ Non-Attorney Representative

Law firm or Company Name (If applicable)

Law Firm Number (If Applicable)

Attorney/Rep First Name MI

Attorney/Rep Last Name

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

City State Zip Code

who requested a fee of $ _____ , having been previously paid $ _____

9. Reason for compromise

10. The undersigned request that this compromise agreement and release be approved.

11. Upon the approval of this compromise agreement as provided by law, and payment in accordance with the provision of the said order of approval, said applicants and each of them do hereby release and forever discharge said employer and said insurance company of and from all claims, demands, actions or causes of action, of every kind or nature whatsoever on account of, or by reason of injury and death sustained as aforesaid by the employee, and in particular of any, all and every claim or cause of action which the undersigned, heirs, executors, representatives, and administrators may have had, now have, or shall hereafter have against said employer, said insurance carrier, and each of them under Division 4 of the Labor Code of the State of California.

12. It is agreed by all parties hereto that the filing of this document is filing of an application on behalf of the applicant and that it may be set 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 date of filing this document, and that it may thereafter be approved, disapproved, or a decision issued after a hearing has been held and the matter regularly submitted.

13. For the purpose of determining the lien claim filed herein for the unemployment compensation disability and / or unemployment compensation benefits which have been paid under or pursuant to California Unemployment Insurance Code, the parties propose the following division of sum agreed upon for settlement and release of this case:

$ _____ for temporary disability covering the period _____ to _____ .

$ _____ for accrued medical expense paid or incurred by the employee.

$ _____ for future medical care.

$ _____ for permanent disability.

(The above segregation must be fair and reasonable and must be based on the real facts of the case. There should be no attempt made to deprive the lien claimant of a reasonable recovery consistent with all amounts involved.)

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)

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)**