DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
P.O. Box 58
Jefferson City, MO 65102-0058

1. INJURY NUMBER

STIPULATION FOR COMPROMISE SETTLEMENT

+ ☐☐ - ☐☐☐☐☐☐

EMPLOYEE	SOCIAL SECURITY NUMBER XXX-XX-	PHONE NUMBER
EMPLOYER	INSURER	

It is hereby stipulated and agreed by and between the parties hereto:

1. That on or about _____, the above-named EMPLOYEE, while in the employment of the above-named employer, sustained an accidental injury/occupational disease arising out of and in the course of the EMPLOYEE'S employment and that an accidental injury/occupational disease resulted in injury to the EMPLOYEE.
2. That both the employer and EMPLOYEE were operating under and subject to the provisions of the Missouri Workers' Compensation Law.
3. That the weekly compensation rate is $ _____ for temporary benefits and $ _____ for permanent partial disability.
4. That employer and insurer have paid medical expenses in the amount of . . . . . $_____
5. That employer and insurer have paid temporary disability for _____ weeks in the amount of $_____
6. That there are dispute(s) between the parties to

7. That because of the dispute(s) it is agreed by the parties to enter into a compromise lump sum settlement under Section 287.390, RSMo, as amended for the payment of a lump sum of . . . . . $_____
   This settlement is based upon approximate disability of _____% of _____
   _____ and that _____ weeks of disfigurement is included.
8. That the SECOND INJURY FUND is making a payment of . . . . . $_____
9. That the preexisting disability and percentage are _____
10. That the EMPLOYER/INSURER shall be responsible for payment or satisfaction of all bills and charges for medical treatment authorized by EMPLOYER or INSURER pertaining to this accident/disease.

ADDITIONAL COMMENTS: _____

THE EMPLOYEE UNDERSTANDS: by entering into this settlement, except as provided by Section 287.140.8, RSMo, the EMPLOYEE is forever closing out this claim under the Missouri Workers' Compensation Law; that EMPLOYEE will receive no further compensation or medical aid by reason of this accident/disease; that EMPLOYEE has the right to a hearing of the EMPLOYEE'S claim, which may result in EMPLOYEE receiving more money or less money than is provided by this settlement; that *EMPLOYER/INSURER and/or SECOND INJURY FUND is/are released from all liability for this accident/disease upon approval by the Administrative Law Judge.* EMPLOYEE asks the Administrative Law Judge to approve this settlement and to allow the EMPLOYEE'S attorney a fee of _____% of any amounts recovered by this settlement. The EMPLOYEE elects to receive payment in one lump sum. The PARTIES by their signatures below agree to the settlement, and the PARTIES request and recommend that this settlement be approved and that the settlement is in accordance with the rights of the parties. The EMPLOYER and EMPLOYEE indicate that the settlement is not the result of undue influence or fraud; the EMPLOYEE fully understands his/her rights and benefits; and the EMPLOYEE voluntarily agrees to accept the terms of the agreement.

By initialing the following box, EMPLOYEE indicates full awareness of the consequences of this settlement as set out above and that EMPLOYEE DID NOT APPEAR IN PERSON BECAUSE OF HARDSHIP OR OTHER EXTENUATING CIRCUMSTANCES. ☐

By initialing the following box, EMPLOYEE indicates full awareness of the consequences of this settlement as set out above and that EMPLOYEE personally appeared. ☐

(Notary is required only if employee is not represented and does not appear.) ***Employee's Signature***

Subscribed and sworn to before me this _____ day of _____. My commission expires:

NOTARY PUBLIC: _____

ATTORNEY FOR EMPLOYEE *(Signature)*	Bar Number *(Print Name)*	Phone Number	Tax I.D. Number

ATTORNEY FOR EMPLOYER/INSURER *(Print Name)* *(Signature)*	Bar Number Phone Number	ATTORNEY FOR SIF *(Print Name)* *(Signature)*	Bar Number Phone Number

FEE/LIEN:	Attorney Fee/Lien in favor of	for $

Settlement and Attorney Fees/Lien APPROVED BY:	ADMINISTRATIVE LAW JUDGE *(Signature)* *(Print Name)*	DATE