WORKERS' COMPENSATION COMMISSION

SETTLEMENT WORKSHEET

Claimant: _____ Claim No.: _____

Claimant Atty.: _____ Atty. Telephone: _____

Claimant's age: _____ years, _____ months

Employer: _____

Insurer: _____

E/I Atty. or Rep.: _____

All questions must be answered. Any incomplete or missing information will cause the Settlement Worksheet to be returned and approval of the settlement delayed.

1. Has this settlement been previously submitted and previously denied? ☐ Yes ☐ No
2. Is the claim contested as to compensability and/or causation? ☐ Yes ☐ No
3. Are further medical treatments recommended for the injury? ☐ Yes ☐ No
4. Is there any potential SIF liability in the case? ☐ Yes ☐ No
5. Is the Claimant working? ☐ Yes ☐ No
6. Does this case involve a third party claim? ☐ Yes ☐ No
   If yes, attach document required by COMAR 14.09.10.02C.
7. Is the claim on appeal? ☐ Yes ☐ No
8. Is a hearing on the claim pending? ☐ Yes ☐ No
   If yes, when? _____
9. Has Claimant applied for Social Security Disability benefits? ☐ Yes ☐ No
   If yes, when (date)? _____
10. Is SSDI claim pending or on appeal? ☐ Yes ☐ No
11. Date SSDI approved: _____ or ☐ N/A
12. Has Claimant applied for Medicare benefits? ☐ Yes ☐ No
    If yes, when (date)? _____
13. Is Medicare claim pending or on appeal? ☐ Yes ☐ No
14. Date Medicare approved: _____ **OR** ☐ N/A

CLICK HERE TO CLEAR FORM

SETTLEMENT WORKSHEET

15. Does Claimant have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

16. **Amount of Total Proposed Settlement:** _____

17. **Total Amount of Indemnity paid to Claimant to date:** _____

18. Has a professional evaluator identified probable future Medicare covered expenses? ☐ Yes ☐ No
    If yes, attach professional evaluation.

19. Has proposed Medicare Set Aside been submitted to CMS? ☐ Yes ☐ No
    If yes, date submitted: _____

20. Is CMS approval of the MSA pending? ☐ Yes ☐ No

21. Date CMS approved MSA: _____ **OR** ☐ N/A

22. Is there a formal medical set aside allocation? ☐ Yes ☐ No
    If yes, state amount: _____

    If yes, is the MSA administered by a TPA or paid as an annuity, with no current or future reversionary interest to claimant? ☐ Yes ☐ No

23. Has some of the settlement been apportioned to future medicals? ☐ Yes ☐ No
    If yes, attach medical evaluation or opinion.

24. Date of disablement by accidental injury or occupational disease: _____

25. Are medicals being left open? ☐ Yes ☐ No

26. Comments:

I hereby certify that the foregoing is true and accurate based on my personal knowledge, information and belief.

Claimant Signature **(Date)** **Attorney Signature** **(Date)**

CLICK HERE TO CLEAR FORM