WORKERS' COMPENSATION COMMISSION

APPLICATION FOR LUMP SUM

INSTRUCTIONS: This form is to be used ONLY for requesting a lump sum payment from a permanent disability award.

CLAIM NUMBER: _____ **CLAIMANT'S NAME:** _____

EMPLOYER: _____

INSURER: _____

AGE _____ **MARITAL STATUS** _____ **# of Dependents** _____

Are you working? No **With/For whom?** _____

What are you making per week? _____ **Social Security Number** _____

How much do you want in a lump sum? _____ **Accident/Occupational Disease Date** _____

Reason (Complete & detailed explanation) ***Continue as attachment if needed***

NOTE: All bills, papers, etc. in support of this request must be attached to this application before it can be considered for approval by the Commission.

- ◯ **Employer/Insurer Consents to the Lump Sum**
- ◯ **SIF Consents to the Lump Sum**
- ◯ **Employer/Insurer Objects, Please Set for Hearing**
- ◯ **SIF Objects, Please Set for Hearing**

I hereby certify that a copy of this request and its documentation has been sent to opposing counsel/parties.

REQUESTED BY:

Full Name _____ **Signature** _____ **Date of Request** _____

☐ **CLAIMANT** ☐ **CLAIMANT'S ATTY** ☐ **EMPLOYER** ☐ **INSURER/EMPLOYER ATTY** ☐ **OTHER:** _____

STREET ADDREESS _____ TELEPHONE _____

CITY _____ STATE _____ ZIP CODE _____

CLICK HERE TO CLEAR THE FORM

WCC H-10 (Rev. 9/03/03)

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