



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

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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)