AmTrust North America
An AmTrust Financial Company

Iowa

Worker's Compensation

Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

Iowa **Division of** Workers' Compensation – FIRST REPORT OF INJURY OR ILLNESS **(FROI)** Jurisdiction Code_____ Jurisdiction Claim Number_____

CLAIM ADMIN

Claim Administrator Name:

Mailing Address, City, State, & Postal Code:
PO Box 89453
Cleveland, OH 44101

Claim Representative Business Phone Number:

Claim Administrator Claim Number:

Claim Administrator FEIN:

Insurer Name (if different than claim administrator):

Insurer FEIN:

Claim Type Code:

EMPLOYER

Employer Name:

Physical Address, City, State, & Postal Code:

Nature of Business:

Employer FEIN:

Mailing Address, City, State, & Postal Code:

Employer Contact Name and Business Phone Number:

Insured Report Number:

Industry Code:

Insured Location Number:

Employer Type Code:
__ Employer (E)
__ Lessor (L)

Employer UI Number:

POLICY

Insured Name (parent company if different than employer):

Insured FEIN:

Insured Postal Code:

Policy/Contract Number:

Coverage Effective Date:

Coverage Expiration Date:

Self Insurance License/ Certificate Number:

EMPLOYEE

Employee Name (First, Middle, Last, & Suffix):

Mailing Address, City, State, & Postal Code:

Email:

Phone Number (include area code):

Occupation Description:

NCCI Classification Code:

Department Where Regularly Worked:

Date of Birth:

Date of Hire:

Gender: __ Transgender (T)
__ Male (M) __ Non-Binary (X)
__ Female (F) __ Unknown(U)

Tax Filing Status (check one):
____ Single (A)
____ Single/Head of Household (B)
____ Married/Filing Joint (C)
____ Married/Filing Separate(D)

State of Hire:

Educational Level (grade completed): _____ [GED = 12]

Marital Status: (check one)
___ Unmarried/Single/Divorced (U)
___ Married (M)
___ Separated (S)

Employment Status (check one):
____ Piece Worker
____ Volunteer
____ Seasonal
____ Apprenticeship/Full-Time
____ Apprenticeship/Part-Time
____ Regular Employee/Full-Time
____ Part-Time
____ Other

Employee ID Number (check one):
ID # _____
____ Social Security Number
____ Employment VISA Number
____ Passport Number
____ Green Card
____ Employee ID Assigned by Jurisdiction

Employee's Authorization to Release the Following:
Medical Records __ yes __ no
Social Security Number __ yes __ no

WAGE

Average Wage $ _____ (check one):
___ hourly ___ daily ___ semi-monthly ___ monthly
___ bi-weekly ___ annual ___ weekly

Number of Days Regularly Worked Per Week: _____

Salary Continued In Lieu of Compensation: ___ yes ___ no

Full Wages Paid for Date of Injury: ___ yes ___ no

Discontinued Fringe Benefits: $_____

Employee Number of Dependents: _____

Employee Number of Exemptions: _____ (check one)
___ Entitled
___ Withholding

ACCIDENT/INJURY

_____ Date of Injury
_____ Date Employer Had Knowledge of the Injury
_____ Date Claim Administrator Had Knowledge of the Injury
_____ Initial Date Last Day Worked
_____ Initial Return to Work Date (if applicable)
_____ Employee Date of Death (if applicable)

_____ Time of Injury

_____ Time Employee Began Work

Pre-Existing Disability Code:
___ Yes
___ No
___ Unknown

Accident Premises Code:
___ Employer (E) ___ Other (X)
___ Lessee (L) ___ Employee Residence (R)

Accident Site Organization Name:

Accident Site Street, City, State, & Postal Code:

Accident Location Narrative (if no street address):

Accident Site County/Parish:

Type of Injury / Illness Code:

Describe the nature of the injury. (ex. amputation, burn, cut, fracture):

Part of Body Affected Code:

Part(s) of body directly affected by the injury or illness. (ex. hand, arm, circulatory system):

Describe the events that caused the injury. (ex. fell, operating machinery, chemical exposure):

Name the object or substance that directly injured the employee. (ex. knife, floor, acid, oil):

Specify activity the employee was engaged in when the event occurred. (ex. cutting metal plate for flooring) Indicate if activity was part of normal duties:

Witness Name & Business Phone Number:

MEDICAL

Initial Treatment Code (check one):
___ no medical treatment (0)
___ minor/on-site treatment (1)
___ clinic/hospital visit (2)
___ emergency care (3)
___ hospitalization > 24 hours (4)
___ future medical treatment/lost time anticipated (5)

Initial Medical Provider Name:

Initial Medical Provider Physical Address, City, State, & Postal Code:

Managed Care Organization Name or ID Number:

ICD Primary Diagnostic Code (if known):

Preparer's Name & Title:

Preparer's Company Name:

Phone Number:

Date:

IOWA DIVISION OF WORKERS' COMPENSATION

www.IowaWorkComp.gov

First Report of Injury or Illness Requirement

An employer or the employer's representative must file with the Iowa Division of Workers' Compensation (DWC) a First Report of Injury or Illness (FROI) in case of occupational:

- Fatality,
- Permanent disability, or
- Temporary disability lasting more than three days.

An employer or the employer's representative must file a FROI within four days of the event.

An employer or the employer's representative must file a FROI if the employee claims the disability is caused by work even if the employer or employer's representative disagrees.

For more information on these and other requirements, go to: www.iowaworkcomp.gov

Records and Reports

Every employer must keep a record of all injuries sustained by employees in the course of their employment resulting in incapacity for longer than one day.

All books, records, and payrolls of an employer must be open for inspection by the Iowa Workers' Compensation Commissioner for purposes of administering the Iowa Workers' Compensation Act.

An employer must furnish to an employee upon request one statement of earnings, wages, or salary for the year preceding the injury. An employer may be subject to a civil penalty of $1,000.00 per offense for failure to furnish such wage statement.

Civil Penalty

The Commissioner may require an employer to appear and show why the employer should not be subject to a civil penalty of $1,000.00 per occurrence for failure to comply with the reporting or inspection requirements. Upon hearing, if the facts indicate, the Commissioner may enter an order requiring payment of such penalty. Unless voluntarily paid, the Commissioner may petition the district court for entry of judgment on the order. The employer's insurance carrier shall be responsible in the same manner and to the same extent as the employer when a report of injury has been submitted to the employer's insurance carrier and not filed by it with the agency.

Additional Iowa OSHA Reporting Requirements

Additional reporting and recordkeeping requirements may apply to the incident described in the FROI.

An employer must:

- Report a workplace fatality to Iowa OSHA within eight hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Report a hospitalization, loss of an eye, or amputation within twenty-four hours by calling 877-242-6742 or visiting www.iowaosha.gov for a form and instructions.
- Complete an OSHA Form 301, or equivalent for recordable, work-related incidents within seven days and retain the completed form on site. The FROI is equivalent to the OSHA Form 301 if the case number from the OSHA 300 log is added. For more information, go to: www.osha.gov/recordkeeping
- Make an entry in your Log of Work-Related Injuries and Illnesses, OSHA Form 300, for recordable cases within seven days and retain the completed form on site. Some industries are exempt from this requirement. For more information, go to: www.osha.gov/recordkeeping

For more information on these and other OSHA requirements, go to: www.iowaosha.gov

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

TYPES OF BENEFITS

MEDICAL BENEFITS

Your employer must pay for all reasonable and necessary medical care required to treat your injury. This includes reasonable and necessary travel expenses for treatment. Mileage for use of a private car is reimbursed at 58 cents per mile. (85.27)

Under certain circumstances, if you are required to leave work for medical treatment, you may receive payment of lost wages.(85.27) A medical care provider cannot seek payment of charges for treatment from you while a contested case proceeding or a dispute as to the reasonableness of a medical treatment fee is pending before the Workers' Compensation Commissioner.(85.27)

DISABILITY BENEFITS

If you are injured at work, you may be entitled to disability benefits.

TYPES OF DISABILITY BENEFITS

Temporary Total Disability (TTD) [85.32, 85.33(1)]

When you are off work more than three calendar days on account of injury, you may be entitled to TTD benefits beginning on the fourth day and continuing until you return to work or are medically recovered enough to return to similar work, whichever happens first. If you are off work for more than 14 calendar days, you may be entitled to payment for the three-day waiting period.

Temporary Partial Disability (TPD) [85.33(2-5)]

If you return to work at a lesser paying job because of the injury, you may be entitled to benefits. The benefit amount is 66 2/3 percent of the difference between your average gross weekly earnings when injured and your actual earnings while temporarily working at the lesser paying job. The three-day waiting period (explained above) also applies to temporary partial disability.

Healing Period (HP) [85.34(1)]

You may be entitled to HP benefits while recovering from an injury which produces a permanent impairment. No waiting period applies to HP benefits. These benefits begin on the first calendar day after the date of injury and continue until the first of the following occurs:

- You return to work
- You have recovered as much as anticipated from the injury
- You are medically capable of returning to the same kind of work you did when injured

Permanent Partial Disability (PPD) [85.34(2)]

When your work injury results in a permanent impairment to your body, a permanent restriction, or an inability to earn wages similar to those earned before your injury, you may be entitled to PPD benefits. PPD benefits are in addition to healing period benefits.

Scheduled Member Disabilities

If your injury is to a scheduled member your PPD benefits are based on functional impairment. Appendix A gives a list of the scheduled body members (i.e. arm, leg, etc.) along with the number of weeks of benefits you would receive for the full loss of each member. If your impairment is less than a full loss, the number of weeks of PPD benefits you may receive is a percentage of loss or loss of use multiplied by the full number of weeks for the member.

Body As A Whole Disabilities

When your work injury results in permanent disability to a part of the body not included as a scheduled member, the disability is considered industrial and is determined by assessing the difference between what you were able to earn prior to the injury and what you are able to earn after the injury. A variety of factors influence the assessment of lost earning capacity. These include the medical condition before the injury, immediately after the injury and now; the part of the body injured; how long you needed to recover from the injury; your work experience and your qualifications intellectually, emotionally, and physically to learn to perform other work; your earnings before and after the injury; your age; education; motivation; functional impairment related to the injury, and loss of ability to do your old job; or loss of earnings because of the injury.

No specific guidelines advise how any factor is to be considered in a particular case. Each industrial disability case must be decided on its facts. Industrial disability is calculated on a 500 week basis with the percentage rating multiplied by 500 weeks.

If the employer offers work at the same or greater wage, an injured employee is only entitled to the functional rating until terminated from employment. The employee can request a reopening and determination of industrial disability.

Permanent Total Disability (PTD) [85.34(3)]

If your work related injury leaves you incapable of returning to any type of wage earning employment, you may be entitled to permanent total disability benefits during that time when you cannot return to any gainful work.

WEEKLY RATE

TTD, HP, PPD or PTD benefits are paid at a weekly workers' compensation rate considering your marital status and number of exemptions. Generally, the rate is 80% of your spendable earnings before any deductions. "Spendable earnings" is the amount remaining after payroll taxes are deducted from your gross weekly earnings.

- The weekly benefit amount is based on a seven day calendar week
- The maximum weekly disability benefit rate for PPD is $1,673
- The maximum weekly disability benefit rate TTD, HP, PTD, and death benefits is $1,819

OTHER BENEFITS

Second Injury Fund Benefits (85.63-85.69)

If you have had a permanent disability to a hand, arm, foot, leg or eye and then have a job related injury that results in permanent partial disability to another hand, arm, foot, leg or eye, you may be entitled to "Second Injury Fund" benefits. These benefits are paid for any amount that industrial disability is greater than the combined scheduled member disability from both the first and second disabled member. These benefits are only paid after your employer or its insurance carrier has paid all scheduled member permanent partial disability benefits due on account of the second injury.

If you believe you are entitled to benefits from this Fund, contact the State of Iowa Treasurer's Office to obtain a claim form.

Vocational Rehabilitation Benefits (85.70)

You may be entitled to payment of $100.00 per week for up to 13 weeks if you are actively participating in a vocational rehabilitation program in order to make it possible for you to return to gainful employment after your injury. If you continue in vocational rehabilitation, the workers' compensation commissioner may extend the $100.00 for an additional 13 weeks.

If you have suffered a shoulder injury, please contact your local IWD office to determine if you are eligible for career vocational training.

Iowa Vocational Rehabilitation Services (IVRS) assists persons with disabilities to prepare, obtain and maintain employment.

Iowa Vocational Rehabilitation Services
510 East 12th Street, Des Moines, IA 50319
800-532-1486 or 515-281-4211

Death Benefits (85.28, 85.31, 85.42, 85.43, 85.44)

If you were dependent on someone who died as a result of an on the job injury, you may be eligible to receive death benefits. A surviving spouse may receive death benefits for life or until remarriage. Dependent children are entitled to death benefits until age 18 or, if actually dependent, age 25. Other persons may qualify for death benefits if they were actually dependent upon the deceased worker. If a surviving spouse remarries and the deceased worker has no dependent children at the time of the remarriage, the surviving spouse is entitled to a two-year lump sum settlement. In addition to the weekly death benefits, the deceased worker's employer (or its insurance carrier) must pay reasonable burial expenses not to exceed twelve times the statewide average weekly wage in effect at the time of death.

TYPES OF SETTLEMENTS

The Workers' Compensation Commissioner must approve all settlements involving work injuries. The law allows four different types of settlements:

FULL COMMUTATION (85.45, 85.47)

A full commutation pays all remaining future benefits in one lump sum. Because an approved full commutation ends all right to additional weekly benefits and may end all rights to medical benefits, it must show that you have a specific need for the full benefit payment now, such that the lump sum payment is in your best interest.

PARTIAL COMMUTATION (85.45, 85.47, 85.48)

A partial commutation pays a part of remaining future weekly benefits in a lump sum. An approved partial commutation contains you and your employer's (and its carrier's) agreement that you are entitled to disability benefits. It does not end your right to future weekly or medical benefits.

AGREEMENT FOR SETTLEMENT (85.35, 86.13)

An agreement for settlement is a voluntary agreement between you and your employer (and its carrier) as to the amount and type of compensation payments you are currently due. The Workers' Compensation Commissioner's approval of the agreement does not end your future rights to additional weekly benefits or additional medical benefits.

COMPROMISE SETTLEMENT (85.35)

A compromise settlement is a voluntary agreement between you and your employers (and its carrier) as to your entitlement benefits. An approved compromise settlement ends any rights to future weekly benefits and may end all rights to medical benefits for the settled injury.

TIME LIMITATIONS

NOTICE OF INJURY (85.23)

Unless your employer has notice or knowledge of your asserted injury within 90 days of its occurrence, you may be denied benefits. The 90-day period begins to run when you knew or should have known that your injurious condition related to your work. When an employee reports a work related injury, the employer must file a first report of injury if the employee loses more than three days of work, or sustains permanent injury or death on account of the injury. The employer (or its carrier) must file the first report within four days of notice or knowledge of the alleged injury with the Workers' Compensation Commissioner.

TWO-YEAR STATUTE OF LIMITATION (85.26)

You must receive Iowa weekly workers' compensation benefits or file an application for arbitration within two years of your alleged injury or benefits may be denied.

THREE-YEAR STATUTE OF LIMITATION (85.26)

If you have received Iowa weekly workers' compensation benefits, you have three years from the last payment of those weekly benefits to receive additional benefits voluntarily, or to file a contested case proceeding for benefits. If you do not file within the three-year period you may be denied additional weekly benefits. (You can file a contested case proceeding or voluntarily receive medical benefits reasonable and necessary to treat your injury throughout your lifetime.)

MEDICAL INFORMATION

Any party making or defending a claim for benefits agrees to release all information concerning the employee's physical or mental condition relative to the claim and waives any privilege for the release of such information. The information shall be made available to any party or the party's representative upon request. (85.27)

Appendix A contains the number of weeks of benefits payable for 100% loss, or loss of use, of the body member. If the PPD rating is less than 100%, the percentage rating is multiplied by the number of weeks shown. For example, a 20% loss, or loss of use, of a thumb would be computed as 20% of 60 weeks, or 12 weeks of PPD benefits.

APPENDIX A

	WEEKS
Loss of thumb	60
Loss of first finger	35
Loss of second finger	30
Loss of third finger	25
Loss of fourth finger	20
Loss of hand	190
Loss of arm	250
Loss of great toe	40
Loss of any other toe	15
Loss of foot	150
Loss of leg	220
Loss of eye	140
Loss of hearing in one ear	50
Loss of hearing in both ears	175
Permanent disfigurement, face or head	150
Body as a whole/industrial disability	500
Shoulder	400

WORKERS' COMPENSATION LAW FOR INJURED WORKERS

- Questions and Answers -

EFFECTIVE JULY 1, 2019 - JUNE 30, 2020

Iowa Workforce Development
Division of Workers' Compensation
150 Des Moines Street · Des Moines, IA 50309
515-725-4120 or 800-645-4583
www.iowaworkcomp.gov
Monday - Friday 8:00 AM - 4:30 PM

This brochure answers questions injured workers commonly ask about workers' compensation. You may check Iowa Code chapters 85 through 87 and 17A, as well as Iowa Administrative Code chapter 876, for detailed information. References to Iowa Code sections and Iowa Administrative Rules appear in parentheses.

WHAT IS WORKERS' COMPENSATION?

The Iowa Workers' Compensation law requires most employers to provide wage loss and medical benefits to employees who are injured while working. [85.61(7)]

TYPES OF INJURIES COVERED

In Iowa, an injury may include any health condition caused by work activities other than the normal building up and tearing down of body tissues. Diseases and hearing losses caused by work activities or exposures are also injuries. (85A, 85B)

Preexisting health conditions are not considered injuries unless work aggravates or worsens them.

ELIGIBILITY FOR WORKERS' COMPENSATION BENEFITS

Most employees who are injured in Iowa while working in Iowa are eligible for benefits.

The law exempts a few types of employees, however. If you are uncertain as to whether employees in your job classification are eligible for benefits, consult with a Workers' Compensation Compliance Administrator with the Division of Workers' Compensation.

Proprietors (independent contractors), limited liability company members and partners are not considered employees. These individuals may be eligible for benefits if they purchase a workers' compensation insurance policy that specifically includes them. [85.1A, 85.61(13)]

CHOOSING THE MEDICAL CARE

The employer has the right to choose the medical care and must provide medical care reasonably suited to treat your injury. If you are dissatisfied with that care, you should discuss the problem with your employer (or its insurance carrier). You can request alternate care, and if your employer (or its carrier) does not allow that care, you may file a petition for alternate medical care before the Iowa Workers' Compensation Commissioner. (85.27)

HOW ARE DISPUTES HANDLED?

When you and your employer (and its insurance carrier) work together and openly communicate, the majority of workers' compensation claim disputes can be resolved. You have a right to know why your employer (and its carrier) has taken any action and the relevant evidence supporting the action.

When a dispute cannot be resolved among the parties, you are encouraged to contact a Workers' Compensation Compliance Administrator in the Iowa Workers' Compensation Commissioner's Office to discuss the situation. If the dispute cannot then be resolved, you may file a contested case proceeding before the Iowa Workers' Compensation Commissioner. While the commissioner does not require it, most employees are represented by legal counsel in a contested case proceeding.

WHO OVERSEES DISPUTES?

The Iowa Workers' Compensation Commissioner is the head of the Division of Workers' Compensation which is part of Iowa Workforce Development. The commissioner is responsible for administering, regulating and enforcing the workers' compensation laws. By law, the Division of Workers' Compensation cannot represent the interest of any party. The Division does provide information regarding the workers' compensation law, the rights of the parties and the procedures the parties can follow to resolve their disputes.

WHO PAYS THE BENEFITS?

Employers subject to the law must either purchase insurance through a private insurance company or qualify as a self-insurer. (85.3, 87.1, 87.11)

If the employer provides coverage by purchasing an insurance policy, the insurance company (or a claim administrator) pays the injured worker the workers' compensation benefits. If the employer is self-insured, the employer (or a claim administrator) pays the injured worker the workers' compensation benefits.

If an employer fails to provide insurance coverage as the law provides, the employee may choose to either file a contested case proceeding before the Workers' Compensation Commissioner or to bring a civil action for damages in the appropriate district court. (87.21)

An employer must either obtain workers' compensation insurance coverage or obtain relief from insurance or furnish a bond before engaging in business. An employer who willfully and knowingly engages in business before doing any of these is guilty of a class "D" felony. (87.14A)

WHEN ARE THE BENEFITS TO BE PAID?

The law encourages prompt payment of weekly and medical benefits so that injured workers will not suffer undue hardship. Most insurance carriers or self-insured employers require a written report of injury (usually from the employer) and medical evidence of the injury before beginning payments. Weekly payments of disability benefits are to begin on the eleventh day of disability. If benefits are not paid when due, you may be entitled to interest on late payments. If benefits are unreasonably delayed or denied, you may be entitled to penalty benefits. (85.30, 86.13)

Once benefits start, payments can only stop when you have returned to work or after your employer (or its carrier) has given you thirty days notice that payments are stopping. The notice must tell you why payments are stopping and advise you that you may file a claim with the Workers' Compensation Commissioner. (86.13)

IOWA DIVISION *of* WORKERS' COMPENSATION

Authorization for Release of Information Regarding Claimant Seeking Workers' Compensation Benefits

Iowa Code section 85.27(2) and Iowa Administrative Code rule 876—8.9 require the release of information relating to an employee's physical or mental condition relative to a workers' compensation claim. Iowa Administrative Code rule 876—4.6 requires the claimant to serve a patient's waiver on the defendant(s) concurrently with an original notice and petition, and to update the waiver as necessary. This form may be used in claims under the jurisdiction of the Iowa Workers' Compensation Commissioner to satisfy the requirements for a claimant seeking workers' compensation benefits to release information.

To complete this form, a workers' compensation claimant or the claimant's representative must:

- Under Section I, sign and date on the labeled blanks to authorize the Iowa Division of Workers' Compensation (DWC) to release confidential information in its custody under Iowa Code section 10A.333.
- Under Section II, sign and date on the labeled blanks to authorize entities other than DWC to release information.
- Under Section III, write "Yes" or "No" next to each of three types of confidential information (substance abuse, mental health, and HIV or AIDS) and then sign and date on the labeled blanks to authorize or refuse to authorize release of such information.

For convenience, Section I of this form incorporates the *Authorization to Release Information to Third Party* form, which is used to authorize DWC to release confidential information to a third party.

Photocopy of this signed authorization shall be as effective as the original.

I. Authorization to Release Information Under the Iowa Workers' Compensation Act.

I understand that I have the right under Iowa Code section 10A.333 to keep confidential certain information filed with DWC.

I authorize DWC to disclose and deliver to _____
all confidential information of any nature in its custody, including:

A. Information from all First Reports of Injury or Illness (FROI);

B. Information from all Subsequent Reports of Injury or Illness (SROI);

C. All evidence received in contested case hearings before the agency; and

D. All transcripts from contested case hearings.

I understand that I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to DWC. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by DWC.

X _____ _____

Signature of Claimant *or* Claimant's Legal Representative — Date

_____

Street Address — City, State, and ZIP Code

_____

If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

II. Authorization for Release of Information and for Redisclosure.

Patient Name: _____ Date of Birth: _____

I authorize _____
to disclose and deliver to _____
any and all information **except** that relating to substance abuse (drug or alcohol), mental health, or HIV and AIDS, unless specifically authorized to be released in Section III of this authorization.

I understand:

A. The information is being disclosed and may be used only for legal and/or litigation purposes relating to claims or suit against _____

B. This authorization may be used to obtain information from health care providers, schools, former and current employers, providers of vocational rehabilitation services, the federal Social Security Administration, and State of Iowa administrative agencies.

C. I have a right to inspect the disclosed information at any time.

D. This authorization is effective until the conclusion of a contested case on the claim.

E. I may revoke this authorization, except to the extent that action has already been taken in reliance upon it, by giving written notice to the health care provider or recordkeeper. I also understand that if I revoke, the revocation will take effect on the day it is received in writing by the entity from whom disclosure is sought.

F. My revocation or refusal to sign this authorization will not affect my ability to obtain health care services.

G. If the person or entity that receives the information requested is not covered by federal privacy regulations or is not an individual or entity who has signed an agreement with such a person or entity, the information described above may be redisclosed and will no longer be protected by the regulations.

H. State of Iowa and federal law provide that I have a right to prohibit redisclosure of confidential medical information and further disclosure may not be had without my express written authorization, except as indicated below.

I. The recipient of this authorization, **without further authorization**, may redisclose this information to the following individuals or entities, but only after they have been advised of their obligations under the law and this authorization, including the redisclosure of information:

1. Parties and their legal counsel, insurers, experts, and potential experts;

2. Agents, employees, or representatives of the parties, but only after they are involved in conducting the prosecution or defense of the case; and

3. Administrative agency and court officials hearing the claim, and their support staff.

I specifically authorize and consent to any disclosure or redisclosure described above.

_____ _____
Signature of Claimant *or* Claimant's Legal Representative Date

_____ _____
Street Address City, State, and ZIP Code

_____
If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

III. Specific Authorization for Release of Information Protected by State or Federal Law Concerning Information Relating to Substance Abuse, Mental Health, or HIV or AIDS.

State of Iowa and federal law provide protection from disclosure of information relating to substance abuse (drug or alcohol), mental health, HIV and AIDS.

Federal law specifically requires that any disclosure or redisclosure of information relating to substance abuse (alcohol or drug), mental health, or HIV or AIDS must be accompanied by the following written statement:

> This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder.

See also Iowa Code chapters 228 and 141A, and other applicable laws.

In addition to the items identified in Section II (A) through (H), I understand:

A. The information to be released may include material that is protected by State of Iowa and federal law applicable to information relating to substance abuse, mental health, or HIV or AIDS.

B. I have a right to inspect the mental health information disclosed pursuant to this authorization at any time.

C. A copy of this authorization with respect to each request for mental health information made using it shall be provided to me or my legal representative and included in my record of mental health information.

I specifically authorize the release of:

_____ Substance abuse (drug or alcohol) information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ Mental health information from all health care providers and facilities and any other person or entity in possession of records concerning me.

_____ HIV- or AIDS-related information, diagnosis, and test results from all health care providers and facilities and any other person or entity in possession of records concerning me.

Further, I specifically authorize disclosure and re-disclosure of this confidential information to all of the persons referred to in Section II(I) of this authorization.

x _____ _____

Signature of Claimant *or* Claimant's Legal Representative | Date

_____

Street Address | City, State, and ZIP Code

_____

If Signed by Claimant's Legal Representative, Full Name of Representative and Relationship to Claimant

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant(s), vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Original Notice & Petition Concerning Independent Medical Examination**

TO THE ABOVE-NAMED DEFENDANT(S):

- You are notified that the above-named claimant filed with the Iowa Division of Workers' Compensation (DWC) this original notice and petition naming you as the defendant(s).
- You must file with DWC an answer or otherwise respond within 20 days of receipt of this document. If you do not, the DWC may enter judgment by default against you for the relief demanded in the petition or impose sanctions under Iowa Administrative Code rule 876—4.36.
- You are advised to seek legal advice at once to protect your interests. If applicable, you should promptly notify your workers' compensation insurance carrier.

PETITION

1. Employer's address: _____
2. Insurance carrier's address : _____
3. Claimant sustained injury arising out of and in the course of employment with the employer on:

   _____
4. Claimant's injury occurred in the following city, county, and state:

   City: _____ County: _____ State: _____
5. Body part(s) affected or disabled: _____
6. An evaluation of permanent disability was made by the following physician:

   _____
7. The physician named in Paragraph 6 was retained or paid by the employer and/or insurance carrier.
8. The injury described in Paragraphs 3 through 5 was a factor in producing the condition for which the physician named in Paragraph 6 performed the evaluation of permanent disability.
9. Claimant believes the evaluation by the physician named in Paragraph 6 is too low.
10. The report containing the evaluation described above is: ☐ Attached. ☐ Not attached.

11. Claimant requests an independent medical examination, at the employer's expenses, under Iowa Code section 85.39 as follows:

    a. Physician Name: _____

    b. Date of Examination: _____

    c. City and State of Examination: _____

12. Claimant: ☐ Waives an evidentiary hearing under Iowa Code section 17A.12.

    ☐ Requests an evidentiary hearing.

Claimant prays the agency award the relief sought under Iowa Code section 85.39 by ordering reimbursement to the claimant of the reasonable fee for the independent medical examination described in Paragraph 10 and all reasonably necessary transportation expenses incurred for the examination.

Signature of Claimant's Attorney – *or* – Self-Represented Claimant

Full Name: _____

Law Firm: _____

Telephone: _____

Email: _____

Mailing Address: _____

_____

_____

PROOF OF SERVICE

I, _____, hereby swear or affirm under Iowa law and the penalty of perjury that, in accordance with Iowa Code section 85.39(2), on the date of _____, I served a copy of the foregoing instrument:

☐ By certified mail, returned receipt requested, on the employer at the address provided in Paragraph 1.

☐ Other: _____

Signature _____ Date _____

IOWA DIVISION *of* WORKERS' COMPENSATION

Information Request Form

Form 14-0083

1. Worker.

Full Name: _____

Social Security Number: _____

Date of Birth: _____

2. Employer.

Business Name(s): _____

3. Workers' Compensation Case(s).

File Number(s) (If Known): _____

Date(s) of Injury (If Known): _____

4. Requestor.

Full Name: _____

Organization (If Any): _____

Email Address: _____

Telephone Number: _____

5. Public Information Requested (If Any).

Mark all public records you are requesting:

☐ Pleadings ☐ Motions ☐ Settlement applications ☐ Decisions ☐ Rulings ☐ Other (described below)

Describe the information you are requesting (if needed):

6. Confidential Information Requested (If Any).

Mark all confidential records you are requesting:

☐ First reports of injury ☐ Subsequent reports of claim activity ☐ Other (described below)

Describe the information you are requesting (if needed):

Under Iowa Code section 10A.333(2), I may receive the requested confidential information because:

- ☐ I have included a waiver, signed by each person whose confidential information is sought, authorizing release of the information.
- ☐ I am the employee whose information is filed with the Iowa Division of Workers' Compensation (DWC).
- ☐ I am a dependent of the employee whose information is filed with DWC.
- ☐ I am an attorney of the employee whose information is filed with DWC.
- ☐ I am an agent, representative, attorney, investigator, consultant, or adjuster of an employer, insurance carrier, or third-party administrator of workers' compensation benefits who is or was involved in administering a claim for such benefits related to the injury or death of the employee whose information is filed with DWC.
- ☐ I am a party to a contested case proceeding before DWC.
- ☐ The person or agent of the person who submitted the information to DWC.
- ☐ I am an agent, representative, attorney, investigator, consultant, or adjuster of an employer, insurance carrier, or third-party administrator of insurance benefits who is or was involved in administering a claim for insurance benefits related to the injury or death of the employee whose information is filed with DWC.
- ☐ I am an authorized agent of a governmental agency (identified as the "Organization" in Section 4 above) that is charged with the duty of enforcing liens or rights of subrogation or indemnity.

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant(s), vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Application for Payment of Benefits Under Iowa Code § 85.21**

1. The employer or insurance carrier, _____, without admitting liability, hereby applies for and consents to an order of the Iowa Workers' Compensation Commissioner under Iowa Code section 85.21 requiring the payment of weekly benefits and authorized medical benefits under Iowa Code chapter 85, 85A, or 85B.
2. Payment of these benefits shall be subject to termination under Iowa Code section 10A.315.
3. Date of injury: _____
4. Claimant's address: _____
5. Employer's address: _____
6. Insurance carrier's address: _____
7. Other parties to dispute: _____

_____

Signature of Attorney for Defendant(s) – *or* – Representative of Defendant(s)

Full Name: _____
Law Firm/Entity: _____
Telephone: _____
Email: _____
Mailing Address: _____

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant(s), vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Application to Defer Payment of Filing Fees & Financial Affidavit**

REQUEST

The undersigned hereby applies to the Iowa Workers' Compensation Commissioner to defer payment of filing fee(s) in my workers' compensation case and in support thereof states the following:

1. My full name is: _____
2. Each of the boxes I have checked below is an accurate statement:
   - ☐ a. I am unable to pay the filing fee(s).
   - ☐ b. I ask the Commissioner for permission to proceed without prepayment of fee(s).
   - ☐ c. I am filing this Application and Affidavit in good faith.
   - ☐ d. I believe I am entitled to what I am asking for in this case.
3. The following number of people live in my household: _____
4. The total amount of monthly income and benefits for all members of my household is: $ _____
5. My monthly income comes from the following salary, wages, benefits, etc.:

   _____

   _____

   _____

   _____

   _____

6. My household has the following monthly expenses:
   - a. Rent or mortgage $ _____
   - b. Utilities $ _____
   - c. Phone $ _____
   - d. Food $ _____
   - e. Transportation $ _____

7. I have $ _____ in cash, checking, and savings.

8. ☐ An attorney did not help me prepare or fill out this application.

   ☐ The following attorney helped me prepare or fill out this Application and Affidavit:

   a. Name of Attorney: _____

   b. Attorney P.I.N. No.: _____

   c. Law Firm or Entity: _____

   d. Business Address: _____

   e. Phone Number: _____

   d. Email Address: _____

CERTIFICATE OF SERVICE

I, _____, certify that on the date of _____ I served a copy of this Application and Affidavit on the other party or the other party's attorney by U.S. Mail or hand-delivery to the following person or entity at the following address:

Name: _____

Address: _____

_____

OATH & SIGNATURE

I, _____, certify under penalty of perjury and under the laws of the State of Iowa that I have read this Application and Affidavit and that the information I have provided in this Application and Affidavit is true and correct.

Signature of Applicant – *or* – Representative of Applicant(s)

Full Name: _____

Law Firm/Entity: _____

Telephone: _____

Email: _____

Mailing Address: _____

_____

_____

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Combination Settlement Under Iowa Code § 85.35(4)**

The undersigned parties submit this Combination Settlement to the Workers' Compensation Commissioner under Iowa Code section 85.35(4). In support of it, the parties agree:

1. Claimant sustained an injury that arose out of and in the course of employment on: _____.

2. Defendant(s) is/are compensating claimant for the disability described in the accompanying Agreement for Settlement without dispute.

3. Defendant(s) dispute(s) other claims made by claimant and the parties are making a full and final disposition of all other such injuries, disabilities, or claims as set forth in the accompanying Compromise Settlement.

Claimant

Name: _____

Date: _____

Representative of Defendant(s)

Name: _____

Date _____

Attorney for Claimant

Name: _____

Date: _____

Attorney for Defendant(s)

Name: _____

Date: _____

The information will be open for public inspection under Iowa Code sections 22.11 and 10A.333(1).

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Agreement for Settlement Under Iowa Code § 85.35(2)**

The parties submit this Agreement for Settlement to the Iowa Workers' Compensation Commissioner for approval under Iowa Code section 85.35(2) and Iowa Administrative Code chapter 876—6. In support of it, the parties agree:

1. Claimant sustained an injury arising out of and in the course of employment on: _____.

2. Jurisdiction exists because: ☐ The injury occurred in Iowa. ☐ Iowa Code section 85.71(____) applies.

3. With respect to rate, under Iowa Code section 85.36(____):
   Marital Status: _____ Exemption(s): _____
   Gross Weekly Wage: _____ Weekly Rate: _____
   If different from weekly rate, permanent partial disability (PPD) weekly rate: _____

4. The injury caused claimant to sustain permanent disability equal to _____ % loss of the _____. Under Iowa Code section 85.34(2)(_____), claimant is entitled to _____ weeks of PPD benefits commencing on the date of _____.

5. For temporary total disability (TTD), temporary partial disability (TPD), permanent partial disability (PPD), permanent total disability (PTD), and/or death benefits, this table shows claimant's entitlement, amount(s) paid by defendant(s), and benefits accrued and not paid.

Type of Benefits	Period(s) of Disability		Weeks & Days Payable		If TPD, Amount Earned	Amount Paid	Accrued & Not Paid
	Start Date thru	End Date	Week(s)	Day(s)	**Total:**		

☐ Check if parties have included an attachment detailing additional periods of disability and payments of benefits.

6. Based on claimant's entitlement to compensation and the benefits paid to date, the remainder is:

_____	x $	_____	= $	_____
Weeks		Weekly Rate		Total

7. Claimant is entitled to other compensation consisting of:

8. Claimant and defendant(s) have agreed to a total settlement amount of: $ _____.

9. Claimant is entitled to medical care for the injury, including future care, as described below:

10. The parties have attached legible supportive evidence, not exceeding 20 pages pursuant to Rule 876-6.6.

11. If claimant is not represented by counsel, a Claimant's Statement (Form 14-0163) has been completed and signed by the claimant and is attached hereto.

12. This settlement waives a hearing, decision, and resulting statutory benefits.

13. The defendant(s) shall file a final Subsequent Report of Injury (SROI) on the Electronic Data Interchange (EDI) and mail to claimant the information in the final SROI, including the date that weekly compensation was last paid, as required under Iowa Administrative Code rules 876—2.6, 876—3.1(2), and 876—11.7.

14. Under Iowa Code sections 85.26(2) and 10A.317, this settlement is subject to review-reopening for three years following the last date that weekly compensation is paid.

CLAIMANT SIGNATURE

I am the person entitled to workers' compensation benefits on account of the indicated injury or death. I have read the foregoing and all attachments. I request this settlement be approved.

_____
Signature of Claimant
Date: _____
Name: _____

_____
Signature of Attorney for Claimant
Date: _____
Name: _____
Law Firm/Entity: _____
Email: _____
Phone: _____
Address: _____

_____ } SS

On this _____ day of _____, _____, before me personally appeared the above claimant to me known to be the identical person named in and who executed the foregoing instrument and acknowledged that the document has been read and executed as a voluntary act.

_____
Notary Public

DEFENDANT(S) SIGNATURE

Defendant(s) _____ have read and understand the foregoing and all attachments and request this settlement be approved.

Signature of Representative of Defendant(s)

Date: _____

Name: _____

Job Title: _____

Entity: _____

Signature of Attorney for Defendant(s)

Date: _____

Name: _____

Law Firm/Entity: _____

Email: _____

Phone: _____

Address: _____

This information will be open for public inspection under Iowa Code sections 22.11 and 10A.333(1).

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Contingent Settlement Under Iowa Code § 85.35(5)**

The undersigned parties submit this Contingent Settlement to the Workers' Compensation Commissioner under Iowa Code section 85.35(5). In support of it, the parties agree:

1. Claimant sustained an injury that arose out of and in the course of employment on: _____.

2. The accompanying settlement and its approval are conditioned upon the occurrence of the following event:

3. If it appears that the contingent event will not occur within one year of the Commissioner's approval of this settlement, during the course of that year, a party may apply to the Commissioner to vacate the settlement or extend the time allowed for the event to occur. If no party so applies within that year, the contingency lapses and the settlement becomes final and fully enforceable.

Claimant	Representative of Defendant(s)
Name: _____	Name: _____
Date: _____	Date _____
Attorney for Claimant	Attorney for Defendant(s)
Name: _____	Name: _____
Date: _____	Date: _____

The information will be open for public inspection under Iowa Code sections 22.11 and 10A.333(1).

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	No(s).: _____ _____ **Compromise Settlement Under Iowa Code § 85.35(3)**

The parties hereby submit this compromise settlement to the Iowa Workers' Compensation Commissioner under Iowa code section 85.35(3) for approval. In support of it, the parties agree:

1. Date of injury: _____

2. A dispute exists under the Iowa Workers' Compensation Law, which the parties seek to resolve by a full and final compromise disposition of claimant's claim for benefits. The subject and nature of the dispute is:

3. If claimant is represented by legal counsel, it is presumed that the required showing for approval of the settlement has been made. If claimant is not represented by an attorney, a claimant statement and evidence of the dispute is attached.

4. As a compromise of their competing interests, the parties agree to the payment and other terms of settlement contained in the attached pages or as follows:

5. In consideration of this payment, claimant releases and discharges the defendant(s) from all liability under the Iowa Workers' Compensation Law for the above compromised claim. In the event a claimant is not represented by counsel, the defendant(s) are responsible for all medical treatment authorized at any time up through the date of approval of the settlement.

STATEMENT OF AWARENESS OF CLAIMANT

I have read the compromise settlement and attached page(s). I understand that the money I receive under this settlement is the total amount I will receive from my claim and that there will not be a hearing and decision on my claim. I am aware that if the Workers' Compensation Commissioner approves this compromise settlement and the defendant(s) pay me the agreed sum, then I am barred from future claims or benefits under the Iowa Workers' Compensation Law for the injury or injuries compromised. I understand I may consult with an attorney of my own choosing for a full explanation of the terms of this document and of my rights under the Iowa Workers' Compensation Law. I have either done so or freely waive my right to do so.

Signature of Claimant

Date: _____

Signature of Attorney for Claimant

Name: _____

Law Firm: _____

Email: _____

Phone: _____

Address: _____

_____

_____ } SS

On this _____ day of _____, _____, before me personally appeared the above claimant to me known to be the identical person named in and who executed the foregoing instrument and acknowledged that the document has been read and executed as a voluntary act.

_____

Notary Public

CONSENT BY DEFENDANT(S)

Defendant(s), _____, consent(s) to the terms of the compromise settlement.

Signature of Representative of Defendant(s)

Name: _____

Job Title: _____

Entity: _____

Signature of Attorney for Defendant(s)

Name: _____

Law Firm: _____

Email: _____

Phone: _____

Address: _____

_____

_____

This information will be open for public inspection under Iowa Code sections 22.11 and 10A.333(1).

STATEMENT OF WAGES/SALARY

IMPORTANT: PLEASE COMPLETE ALL INFORMATION REQUESTED

Employee: Employer: Claim Number:
Social Security Number: Date of Hire: Position/Job Title

EMPLOYMENT TYPE: Full Time____Part Time____Seasonal____Temp_____
If Temporary or Seasonal worker, last day of season or job end date _____
WAGE TYPE: Hourly____Salary____Commission____
WAGE INFORMATION:
$_____ per hour ; Monthly Wage $_____ ; Does monthly wage include commission ____Yes ___No
Hours per Week _____ ; Overtime Rate $_____per hour ; Overtime Hours Regularly Worked per week ____
Tips reported: $_____ per week

If employees' compensation package includes an allowance for any of the following, please indicate the actual or estimated value:
Meals: $_____per week Auto: $_____ Rent/Lodging: $_____per week Bonus $_____ per __wk__mth__yr

PLEASE COMPLETE THE BELOW FOR THE PERIOD _____ TO _____

WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary	WK	Pay Rate	Hrs Worked	Begin Date	End Date	Gross Salary
1						27					
2						28					
3						29					
4						30					
5						31					
6						32					
7						33					
8						34					
9						35					
10						36					
11						37					
12						38					
13						39					
14						40					
15						41					
16						42					
17						43					
18						44					
19						45					
20						46					
21						47					
22						48					
23						49					
24						50					
25						51					
26						52					