FORM 9 - 14-0013 (11/06)

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

File No._____

_____ Claimant VS. _____ (Injury Date)

Compliance File No. _____ (REQUIRED)

_____ Employer

_____ Insurance Carrier

ORIGINAL NOTICE AND PETITION AND ORDER FOR COMMUTATION OF ALL REMAINING BENEFITS OF 10 WEEKS OR MORE 876 IAC 6.2(6)

To Employer and Insurance carrier: You are notified that an action for commutation of all remaining benefits has been commenced before the workers' compensation commissioner seeking relief under the chapters of the Iowa Code relating to workers' compensation, occupational disease and occupational hearing loss (Chapter 85, 85A, 85B, 86 and 87). A hearing will be held in the judicial district wherein the injury occurred. When applicable, the parties will be notified by the workers' compensation commissioner of the time and place of the prehearing conference and hearing. **You are required to file an answer within 20 days of the receipt of this document** or to otherwise move or respond as provided by Rule 876 IAC 4.9. Failure to comply may result in the imposition of the sanctions of 876 IAC 4.36.

Payment Activity Report (PAR) shall match calculation below.

A. The undersigned makes Application for Full Commutation of all remaining benefits in the above entitled case and represents:

1. As a result of the compensable injury or death, claimant has suffered a permanent disability equal to _____ % of the _____
2. Total Entitlement ..... Temporary Partial / Healing Period / Permanent/Death

   Weeks _____ Weeks _____ Weeks _____

   $ _____ $ _____

   Amount Paid _____ Rate _____ Rate _____ $ _____ Total

3. Paid to Date ..... Temporary Partial / Healing Period / Permanent/Death

   Weeks _____ Weeks _____ Weeks _____

   $ _____ $ _____

   Amount Paid _____ Thru _____ Date Thru _____ Date $ _____ Total

4. Accrued-Not Paid ..... Temporary/Partial / Healing Period / Permanent/Death

   Weeks _____ Weeks _____ Weeks _____

   $ _____ $ _____

   Amount Paid _____ Thru _____ Date Thru _____ Date $ _____ Total

5. Remainder ..... _____ Weeks @ $ _____ Total $ _____
6. Commuted Value ..... _____ Factor X _____ Weekly Rate = $ _____ Commuted Value
7. Other Terms

_____

B. Attach pertinent, legible medical records not exceeding 20 pages indicating:
   (1) The degree of disability
   (2) The condition is not expected to deteriorate
   (3) The condition is not expected to require future treatment (unless provision has been made for future treatment)

C. Statement of Need in dollars and cents. I will use the funds for the following:

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____
4. _____ $ _____

Attorney fee disclosure:

$_____ = _____ % of settlement

D. 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. Upon receipt of the indicated sums and approval by the workers' compensation commissioner, I release and discharge the named employer and insurance carrier from **all liability** under the Iowa Workers Compensation Law which is now in existence or may exist in the future on account of the indicated injury.

I consent to the degree of disability and the granting of the commutation. In the event the employer consents to the commutation, I waive any provision concerning contested cases as provided in Chapter 17A or otherwise.

If I am not represented, I waive my right to an attorney

_____ _____

Claimant's Attorney Date Claimant Date

_____ _____

Email Address of Attorney Fax Number of Attorney

State of Iowa

_____ } 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

E. EMPLOYER

1. The employer/insurance carrier consents to the degree of disability and the granting of the commutation and waives any provision concerning contested cases as provided in Chapter 17A or otherwise.

_____

Employer/Insurance Carrier Date

Email Address _____

Fax Number _____

2. The employer/insurance carrier resists the relief sought in the petition for commutation but acknowledges delivery of a copy of the original notice and petition.

(Check one) ☐ A hearing is waived ☐ A hearing is requested

_____

Employer/Insurance Carrier Date

Email Address _____

Fax Number _____

The foregoing Application for Commutation is approved and the relief sought is granted _____ , _____.

_____

Iowa Workers' Compensation Commissioner

NOTICE TO APPLICANT

DELIVERY OF FORM

1. Delivery of this form is to be by personal service as in civil actions or by certified mail, return receipt requested. Rule 876 IAC 4.7.
2. A copy of this form with proof of delivery and claimant's confidential information sheet, must be filed with the Division of Workers' Compensation no later than 10 days after delivery upon the respondent. Rule 876 IAC 4.8.
3. The Commissioner will not deliver this form to the respondent for a petitioner.

IOWA WORKFORCE DEVELOPMENT

DIVISION OF WORKERS' COMPENSATION, 1000 EAST GRAND AVENUE, DES MOINES, IOWA 50319-0209 (515) 281-5387

The information provided will be open for public inspection under Iowa Code §§ 22.11 and 86.45(1)