

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____	:	Contested Case File No.: _____
Claimant,	:	
vs.	:	Compliance File No.: _____
_____	:	Injury Date: _____
Employer,	:	
and	:	COMBINATION SETTLEMENT
_____	:	[Iowa Code Section 85.35(4)]
Insurance Carrier,	:	
Defendants.	:	

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

1. The claimant sustained an injury that arose out of and in the course of the employment on _____ (date of injury).
2. The employer/insurance carrier is compensating claimant for the disability described in the accompanying Agreement for Settlement without dispute.
3. The employer/insurance carrier disputes other claims made by claimant that claimant attributes to the employer, 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	Date	Employer/Insurance Carrier	Date

_____	_____	_____	_____
Claimant's Attorney	Date	Employer/Carrier's Attorney	Date

Approved as part of the accompanying settlements this _____ day of _____, 20____

Iowa Workers' Compensation Commissioner

The information provided will be open for public inspection under Iowa Code §§ 22.11 and 86.45(1).
14-0159 (02/15)

