

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.
 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	

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	
Email Address of Attorney	Fax Number of Attorney

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 of Attorney	Fax Number of Attorney

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 statement 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.

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)