

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

<p style="text-align: center;">vs.</p> <p style="text-align: center;">_____ Claimant,</p> <p style="text-align: center;">_____ Employer,</p> <p style="text-align: center;">_____ Insurance Carrier,</p> <p style="text-align: center;">_____ Defendant(s).</p>	<p>No(s).: _____ _____</p> <p align="center">Agreement for Settlement Under Iowa Code § 85.35(2)</p>
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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. At the time of the injury, claimant:
 - a. Was: Single. Married.
 - b. Entitled to _____ exemption(s).
 - c. Had gross weekly earnings of \$ _____ under Iowa Code section 85.36(____).

Based on the above, claimant has a workers' compensation rate of \$ _____ per week.

If the rate for permanent partial disability (PPD) benefits differs, it is \$ _____ per week.

4. The below table shows claimant's entitlement to temporary partial disability (TPD), healing period (HP), permanent total disability (PTD), and/or death benefits; benefits paid by defendant(s); and benefits accrued but not paid.

Type of Benefits	Period(s) of Disability	Weeks & Days Payable	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.

5. The injury caused claimant to sustain permanent disability equal to _____ % loss of the _____ and parties have attached relevant doctors' and practitioners' reports.
6. Under Iowa Code section 85.34(____), claimant is entitled to _____ weeks of PPD benefits commencing on the date of _____.
7. Defendant(s) have paid claimant PPD benefits as follows:
- _____ x \$ _____ = \$ _____
- Weeks Rate Total
8. Claimant is entitled to other compensation or benefits consisting of:
9. Based on claimant's entitlement to compensation or benefits and the benefits paid to date, the remainder is:
- _____ x \$ _____ = \$ _____
- Weeks Total
10. Claimant and defendant(s) have agreed to a total settlement amount of: \$ _____.
11. Claimant is entitled to medical care for the injury, including care in the future, as described below:
12. A Claimant Statement (Form 14-0163), which claimant has personally completed, certified and signed, is:
- Not attached because claimant is represented by counsel.
 - Attached because claimant is not represented by counsel.
13. Accompanying documentation:
- Totals 20 or fewer pages.
 - In accordance with an order issued by the Commissioner or a deputy commissioner, totals more than 20 pages.
14. This settlement waives a hearing, decision, and resulting statutory benefits. 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.
15. 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.

CLAIMANT SIGNATURE

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

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

DEFENDANT(S) SIGNATURE

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

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).



Iowa Department of **INSPECTIONS APPEALS & LICENSING**
Division of **WORKERS' COMPENSATION**
Agreement for Settlement Under Iowa Code Section 85.35(2)
Form 14-0021 — Last Updated July 1, 2023
www.IowaWorkComp.gov

