Before the Iowa Workers' Compensation Commissioner

______________________, Claimant, vs. ______________________, Employer, ______________________, Insurance Carrier, ______________________, Defendant(s).	File 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 the following date: ______________________
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	Employer/Insurance Carrier
Name: ______________	Name: ______________
Date: ______________	Date ______________

Attorney for Claimant	Attorney for Employer/Insurance Carrier
Name: ______________	Name: ______________
Date: ______________	Date: ______________

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