BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	File No(s).: _____ _____ **Compromise Settlement Under Iowa Code § 85.35(3)**

1. Date of injury: _____

2. The undersigned parties submit this Compromise Settlement under Iowa Code section 85.35(3).

3. A dispute exists under the Iowa Workers' Compensation Law, which the parties seek to resolve by a full and final compromise disposition of claimant's claim for benefits. The subject and nature of the dispute is:

4. If claimant is represented by legal counsel, it is presumed that the required showing for approval of the settlement has been made. If claimant is not represented by an attorney, a claimant statement and evidence of the dispute is attached.

5. As a compromise of their competing interests, the parties agree to the payment and other terms of settlement contained in the attached pages or as follows:

6. RELEASE. In consideration of this payment, claimant releases and discharges the above employer and insurance carrier from all liability under the Iowa Workers' Compensation Law for the above compromised claim. In the event a claimant is not represented by counsel, defendants are responsible for all medical treatment authorized at any time up through the date of approval of the settlement.

7. STATEMENT OF AWARENESS OF CLAIMANT. I have read the compromise settlement and attached page(s). I understand that the money I receive under this settlement is the total amount I will receive from my claim and that there will not be a hearing and decision on my claim. I am aware that if the Workers' Compensation Commissioner approves this compromise settlement and the employer/insurance carrier pays me the agreed sum, then I am barred from future claims or benefits under the Iowa Workers' Compensation Law for the injury or injuries compromised. I understand I may (1) consult with an attorney of my own choosing, or (2) call the Iowa Division of Workers' Compensation at 1-800-645-4583, or both in order to receive a full explanation of the terms of this document and of my rights under the Iowa Workers' Compensation Law. I have either done so or freely waive my right to do so.

Claimant

Name: _____

Date: _____

Attorney for Claimant

Name: _____

Date _____

Subscribed and sworn to by claimant before me on this _____day of _____, _____.

Notary Public

8. EMPLOYER/INSURANCE CARRIER. The employer/insurance carrier consents to the compromise settlement.

Employer/Insurance Carrier

Name: _____

Date: _____

Attorney for Employer/Insurance Carrier

Name: _____

Date: _____

9. SECOND INJURY FUND. The Second Injury Fund consents to the compromise settlement.

Second Injury Fund of Iowa

Name: _____

Date: _____

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