BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

_____, Claimant, vs. _____, Employer, _____, Insurance Carrier, _____, Defendant(s).	File No(s).: _____ _____ **Original Notice & Petition for Full Commutation of All Remaining Benefits of 10 Weeks or More**

ORIGINAL NOTICE TO DEFENDANT(S)

- You are notified that an action for full commutation of all remaining benefits of 10 weeks or more has been commenced before the Iowa Workers' Compensation Commissioner seeking relief under Iowa Code chapters 85, 85A, 85B, and 87, which govern workers' compensation, occupational disease, and occupational hearing loss.
- You are required to file an answer within 20 days of receipt of this document or to otherwise respond as provided in Rule 876 IAC 4.9. Failure to comply may result in the imposition of sanctions under Rule 876 IAC 4.36.
- Payment Activity Report (PAR) shall match the calculation below.

PETITION

A. Date of Injury: _____

B. The undersigned makes application for full commutation of all remaining benefits in the above-captioned case and represents:

1. As a result of the compensable injury or death, the claimant has suffered a permanent disability equal to _____ % of the _____.
2. Total Entitlement:

	Temporary Partial		Healing Period		Permanent/Death		
Weeks:	_____	Weeks:	_____	Weeks:	_____		
		$	_____	$	_____		
Amount Paid:	_____	Rate:	_____	Rate:	_____	$	_____
							Total

3. Paid to Date:

	Temporary Partial		Healing Period		Permanent/Death		
Weeks:	_____	Weeks:	_____	Weeks:	_____		
		$	_____	$	_____		
Amount Paid:	_____	Thru:	_____	Thru:	_____	$	_____
			Date		Date		Total

4. Accrued-Not Paid:

Temporary Partial		Healing Period		Permanent/Death		
Weeks:		Weeks:		Weeks:		
		$		$		
Amount Paid:		Thru:		Thru:	$	
		Date		Date	Total	

5. Remainder:

_____ Weeks @ $ _____ = Total $ _____

6. Commuted Value:

_____ X _____ = $ _____

Factor | Weekly Rate | Commuted Value

7. Other Terms.

C. Attach pertinent, legible medical records not exceeding 20 pages indicating:

1. The degree of disability.
2. The condition is not expected to deteriorate.
3. The condition is not expected to require future treatment (unless provision has been made for future treatment).

D. State of Need in Dollars and Cents. I will use the funds for the following:

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____
4. _____ $ _____

Attorney Fee Disclosure:

$ _____ = _____ % of settlement.

E. Claimant Consent.

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. Upon receipt of the indicated sums and approval by the Workers' Compensation Commissioner, I release and discharge the named employer and insurance carrier from all liability under the Iowa Workers' Compensation Law which is now in existence or may exist in the future on account of the indicated injury. I consent to the degree of disability and the granting of commutation. In the event the employer consents to the commutation, I waive any provision concerning contested cases as provided in Iowa Code Chapter 17A or otherwise.

Signature of Claimant

Date: _____

Signature of Claimant's Attorney

Name: _____

Date: _____

Email: _____

Phone: _____

Fax _____

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

F. Employer Consent.

The employer/insurance carrier consents to the degree of disability and the granting of the commutation and waives any provision concerning contested cases as in Iowa Code Chapter 17A or otherwise.

Employer/Insurance Carrier

Attorney for Employer/Insurance Carrier

Name: _____

Email: _____

Phone: _____

Fax _____

Address: _____

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