Print Form

FORM 117

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA Board #
(If Known):

AGREEMENT FOR REDEEMING LIABILITY BY LUMP SUM UNDER G.L. CH. 152 FOR INJURIES OCCURRING ON OR AFTER NOV. 1, 1986

Please Print or Type

EMPLOYEE _____ **LUMP SUM AMOUNT $**_____

EMPLOYER _____ TOTAL DEDUCTIONS $_____

INSURER _____ NET TO CLAIMANT $_____

BOARD NUMBER _____ TOTAL PAYMENTS $_____
(Weekly benefits plus lump sum)

DATE OF INJURY_____

CHECK WHERE APPLICABLE

( ) Liability has been established by acceptance or by standing decision of the Board, the Reviewing Board, or a court of the Commonwealth and this settlement shall not redeem liability for the payment of medical benefits and vocational rehabilitation benefits with respect to such injury.

( ) Liability has **NOT** been established by standing decision of the Board, the Reviewing Board, or a court of the Commonwealth and this settlement shall redeem liability for the payment of medical benefits and vocational rehabilitation benefits with respect to such injury.

( ) In addition to the lump-sum, the insurer agrees to pay all outstanding reasonable and related medical bills incurred as of this date.

( ) The employee is currently receiving a cost-of-living adjustment.

DEDUCTIONS: From the lump-sum amount as stated above, the amount(s) listed below will be deducted and paid directly to the following parties:

	NAME	ADDRESS
1. $_____ Attorney's Fee	_____	_____
2. $_____ Attorney's Expenses	_____ (Please attach documentation)	_____
3. $_____ Liens	_____ (Please attach discharges)	_____
4. $_____ Inchoate Rights	_____ (Please specify release)	_____
5. $_____	_____	_____
6. $_____	_____	_____
7. $_____	_____	_____

(OVER)

EMPLOYEE MEDICAL INFORMATION:

Age _____ No. of Dependents _____ Average Weekly Wage $_____ Compensation Rate $_____

Social Security No.*: _____-____-_____ Occupation _____ Educational Background _____

On Social Security: YES (☐) NO (☐)

On Public Employee Disability Retirement: YES (☐) NO (☐)

DIAGNOSIS _____ PRESENT MEDICAL CONDITION _____

_____ _____

Present Work Capacity: _____ Third Party Action _____

PLEASE GIVE A BRIEF HISTORY OF THE CASE AND INDICATE WHY THE SETTLEMENT IS IN THE EMPLOYEE'S BEST INTEREST (Specify all allocations):

(Please attach a separate sheet if necessary.)

Received of _____ the Lump Sum of _____

_____ dollars and _____ cents ($_____)

This payment is received in redemption of the liability of all weekly payments now or in the future due me under the Workers' Compensation Act, for all injuries received by_____

on or about _____ while in the employ of _____

_____. **I fully understand that after all of the deductions herein I will receive $_____. I am fully satisfied with and request approval of this settlement. This agreement has been translated for me into my native language of _____.**

	SIGNATURE	ADDRESS	ZIP CODE
CLAIMANT:	_____		
	_____		
CLAIMANT'S COUNSEL:	_____	_____	
	_____		
INSURER'S COUNSEL:	_____		

Signed this _____ day of _____ 20____

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of this document.