

RETURN TO:
OFFICE OF WORKERS' COMPENSATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9040
(225) 342-7565
TOLL FREE (800) 201-3457

1. Social Security No. _____ - _____ - _____
2. Date of Injury/Illness _____ - _____ - _____
3. Part(s) of Body Injured _____
4. OWC Docket Number _____
5. OWC District Number _____

**REQUEST FOR COMPROMISE
OR LUMP SUM SETTLEMENT**

DATE OF APPROVAL

JUDGE

EMPLOYEE

6. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone _____

EMPLOYEE'S ATTORNEY

7. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone _____

EMPLOYER

8. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone _____

**INSURER/ADMINISTRATOR
(circle one)**

9. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone _____

**EMPLOYER/INSURER'S ATTORNEY
(circle one)**

10. Name _____
Street or Box _____
City _____
State _____ Zip _____
Phone _____

11. DATE OF SETTLEMENT CONFERENCE _____

12. TERMS AND AMOUNT OF SETTLEMENT: _____

13. BENEFITS PAID TO DATE:

a.) AVERAGE WEEKLY WAGE: _____

b.) WORKERS' COMPENSATION BENEFITS: _____

c.) MEDICAL BENEFITS: _____

d.) DEATH BENEFITS: _____

14. ATTORNEY FEES PAID TO DATE: _____

15. ADDITIONAL FEES REQUIRED: _____

ATTACHMENTS REQUIRED:

_____ JOINT PETITION
_____ FORM 1007 ATTACHED _____ OR ON FILE _____
_____ FORM 1003 ATTACHED _____ OR ON FILE _____
_____ EMPLOYEE AFFIDAVIT
_____ EMPLOYER CONCURRENCE
_____ ALLEGATION OF LEGAL REPRESENTATION

_____ MOST RECENT MEDICAL REPORT
_____ WAIVER OF RIGHTS UNDER L.R.S. 23:1271
_____ FILING FEE PAID
_____ ORDER OF APPROVAL
_____ MOTION AND ORDER FOR ATTORNEY FEES
_____ MOTION AND ORDER TO DISMISS 1008
(IF APPLICABLE)

SUBMITTED BY: _____

PHONE: _____