



STATE OF CALIFORNIA
 DIVISION OF WORKERS' COMPENSATION
 WORKERS' COMPENSATION APPEALS BOARD
 COMPROMISE AND RELEASE



Case Number 1 _____

Case Number 4 _____

Case Number 2 _____

Case Number 5 _____

Case Number 3 _____

SSN (Numbers Only) _____

Venue Choice is based upon: (Completion of this section is required)

- County of residence of employee (Labor Code section 5501.5(a)(1) or (d).)
- County where Injury occurred (Labor Code section 5501.5(a)(2) or (d).)
- County of principal place of business of employee's attorney (Labor Code section 5501.5(a)(3) or (d).)

SDO _____

Select 3 Letter Office Code For Place/Venue of Hearing (From Document Cover Sheet)

Employee (Completion of this section is required)

First Name _____ MI

Last Name _____

Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ CA 92083
 State Zip Code

Employer Information (Completion of this section is required)

- Insured
- Self-Insured
- Legally Uninsured
- Uninsured

CORPORATION

Employer Name (Please leave blank spaces between numbers, names or words) _____

Employer Street Address/PO Box (Please leave blank spaces between numbers, names or words) _____

City _____ CA 92024
 State Zip Code

2019 MAY 10 AM 8:17
 RECEIVED
 DIVISION OF WORKERS' COMPENSATION

Claims Administrator Information (if known and if applicable)

Name (Please leave blank spaces between numbers, names or words)

Street Address/PO Box (Please leave blank spaces between numbers, names or words)

City KY 40512
State Zip Code

IT IS CLAIMED THAT:

1. The injured employee, born (DATE OF BIRTH: MM/DD/YYYY), alleges that while employed as a(n)



STOCKER, sustained injury (OCCUPATION AT THE TIME OF INJURY)

arising out of and in the course of employment at the locations and during the dates listed below:

(State with specificity the date(s) of injury(ies) and what part(s) of body, conditions or systems are being settled.)

[X] Specific Injury

[] Cumulative Injury

08/13/2007

(Start Date: MM/DD/YYYY)

(End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: 100 HEAD Body Part 2: 120 EAR Body Part 3: 200 NECK

Body Part 4: 840 NERVOUS Other Body Parts: 842 NERVOUS

The injury occurred at (Street Address/PO Box - Please leave blank spaces between numbers, names or words)

ENCINITAS CA 92024
City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 2

Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 3

Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 4

Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

City State Zip Code

Body parts, conditions and systems may not be incorporated by reference to medical reports.

Specific Injury

Case Number 5 _____

Cumulative Injury

(Start Date: MM/DD/YYYY)
(If Specific Injury, use the start date as the specific date of injury)

(End Date: MM/DD/YYYY)

Body Part 1: _____ Body Part 2: _____ Body Part 3: _____

Body Part 4: _____ Other Body Parts: _____

The injury occurred at _____
(Street Address/PO Box - Please leave blank spaces between numbers, names or words)

_____ City _____ State _____ Zip Code _____

Body parts, conditions and systems may not be incorporated by reference to medical reports.

2. Upon approval of this compromise agreement by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge and payment in accordance with the provisions hereof, the employee releases and forever discharges the above-named employer(s) and insurance carrier(s) from all claims and causes of action, whether now known or ascertained or which may hereafter arise or develop as a result of the above-referenced injury(ies), including any and all liability of the employer(s) and the insurance carrier(s) and each of them to the dependents, heirs, executors, representatives, administrators or assigns of the employee. Execution of this form has no effect on claims that are not within the scope of the workers' compensation law or claims that are not subject to the exclusivity provisions of the workers' compensation law, unless otherwise expressly stated.

3. This agreement is limited to settlement of the body parts, conditions, or systems and for the dates of injury set forth in Paragraph No. 1 and further explained in Paragraph No. 9 despite any language to the contrary elsewhere in this document or any addendum.

4. Unless otherwise expressly stated, approval of this agreement RELEASES ANY AND ALL CLAIMS OF APPLICANT'S DEPENDENTS TO DEATH BENEFITS RELATING TO THE INJURY OR INJURIES COVERED BY THIS COMPROMISE AGREEMENT. The parties have considered the release of these benefits in arriving at the sum in Paragraph 7. Any addendum duplicating this language pursuant to Sumner v WCAB (1983) 48 CCC 369 is unnecessary and shall not be attached.

5. Unless otherwise expressly ordered by the Workers' Compensation Appeals Board or a workers' compensation administrative law judge, approval of this agreement does not release any claim applicant may have for vocational rehabilitation benefits or supplemental job displacement benefits.

6. The parties represent that the following facts are true: (If facts are disputed, state what each party contends under Paragraph No. 9.)

EARNINGS AT TIME OF INJURY \$ 478.58

TEMPORARY DISABILITY INDEMNITY PAID 8,226.93 Weekly Rate \$ 319.05

Period(s) Paid 08/14/2007 03/01/2009
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

PERMANENT DISABILITY INDEMNITY PAID 24,035.00 Weekly Rate \$ 230.00

Period(s) Paid 03/03/2009 End date 05/19/2015
(Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

TOTAL MEDICAL BILLS PAID \$ 229,972.53 Total Unpaid Medical Expense to be Paid By: DEF PER PARA 8

Unless otherwise specified herein, the employer will pay no medical expenses incurred after approval of this agreement.

7. The parties agree to settle the above claim(s) on account of the injury(ies) by the payment of the SUM OF

\$ 300,000.00

Settlement Amount

The following amounts are to be deducted from the settlement amount:

\$ _____ for permanent disability advances through _____

\$ _____ for temporary disability indemnity overpayment, if any.

\$ 205,000.00 payable to STRUCTURE ANNUITY PER ATTACHED ADDENDUM

\$ _____ payable to _____

\$ _____ payable to _____

\$ _____ payable to _____

\$ 35,000.00 requested as applicant's attorney's fee.

LEAVING A BALANCE OF \$ 60,000.00 , after deducting the amounts set forth above and less further permanent disability advances made after the date set forth above. Interest under Labor Code section 5800 is included if the sums set forth herein are paid within 30 days after the date of approval of this agreement.

8. Liens not mentioned in Paragraph No. 7 are to be disposed of as follows (Attach an addendum if necessary):

DEFENDANTS TO PAY, ADJUST OR LITIGATE ALL LIENS OF RECORD WITH JURISDICTION RESERVED TO THE WCAB.

9. The parties wish to settle these matters to avoid the costs, hazards and delays of further litigation, and agree that a serious dispute exists as to the following issues (Initial only those that apply). ONLY ISSUES INITIALED BY THE APPLICANT OR HIS/HER REPRESENTATIVE AND DEFENDANTS OR THEIR REPRESENTATIVES ARE INCLUDED WITHIN THIS SETTLEMENT.

<u>Applicant</u>	<u>Defendant</u>	
P.R	SA	earnings
P.R	SA	temporary disability
P.R	SA	jurisdiction
P.R	SA	apportionment
P.R	SA	employment
P.R	SA	injury AOE/COE
P.R	SA	serious and willful misconduct
P.R	SA	discrimination (Labor Code §132a)
P.R	CA	statute of limitations
P.R	SA	future medical treatment
P.R	SA	other <u>MILEAGE; OUT OF POCKET EXPENSES; PENALTIES; INTEREST</u>
P.R	SA	permanent disability
P.R	SA	self-procured medical treatment, except as provided in Paragraph 7
P.R	SA	vocational rehabilitation benefits/supplemental job displacement benefits

COMMENTS:

SEE ATTACHED ADDENDA.
 \$205,000 PAYABLE TO FUND ANNUITY
 \$35,000 ATTORNEY FEES
 \$60,000 CASH TO APPLICANT

CASE NUMBER PREVIOUSLY DISMISSED WITH PREJUDICE IN STIPULATION AND
 AWARD DATED

Any accrued claims for Labor Code section 5814 penalties are included in this settlement unless expressly excluded.

10. It is agreed by all parties hereto that the filing of this document is the filing of an application, and that the workers' compensation administrative law judge may in its discretion set the matter for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein and that if hearing is held with this document used as an application, the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that the workers' compensation administrative law judge may thereafter either approve this Compromise and Release or disapprove it and issue Findings and Award after hearing has been held and the matter regularly submitted for decision.

11. WARNING TO EMPLOYEE: SETTLEMENT OF YOUR WORKERS' COMPENSATION CLAIM BY COMPROMISE AND RELEASE MAY AFFECT OTHER BENEFITS YOU ARE RECEIVING TO WHICH YOU BECOME ENTITLED TO RECEIVE IN THE FUTURE FROM SOURCES OTHER THAN WORKERS' COMPENSATION, INCLUDING BUT NOT LIMITED TO SOCIAL SECURITY, MEDICARE AND LONG-TERM DISABILITY BENEFITS.

THE APPLICANT'S (EMPLOYEE'S) SIGNATURE MUST BE ATTESTED TO BY TWO DISINTERESTED PERSONS OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC

By signing this agreement, applicant (employee) acknowledges that he/she has read and understands this agreement and has had any questions he/she may have had about this agreement answered to his/her satisfaction.

Witness the signature hereof this 7th day of May, 2018 at Escondido, CA

Witness 1 5-7-18
(Date)

Witness 2 5-7-18
(Date)

Interpreter _____ (Date)

5/07/18
Applicant (Employee) _____ (Date)

5/7/18
Attorney for Applicant _____ (Date)

5/8/2018
Attorney for Defendant _____ (Date)

Attorney for Defendant _____ (Date)

Attorney for Defendant _____ (Date)

Attorney for Defendant _____ (Date)

ADDENDUM A

CONDITIONS FOR THIS COMPROMISE

Case previously resolved via Stipulations and Award based on the reporting of AMEs and Dr.

Applicant desires to control future medical care. Defendants wish to buy their peace. All parties agree that the C&R is fair and reasonable. The C&R includes all aspects of injury which may hereafter arise or develop as a result of said injury.

Unpaid medical expense will be paid by defendant only if reasonable and necessary and incurred prior to the order approving this settlement. Applicant stipulates defendants complied with CCR sections 9767.6 and 9767.12, and that applicant was properly notified of defendant's MPN.

It is not the intention of the carrier or anyone else a part of this agreement to shift the responsibility for any future medical care as it relates to the industrial injury stated in the C&R onto Medicare. Claimant is not now eligible nor has Claimant applied for Social Security/Medicare. Claimant at this time has no intention of applying for Social Security/Medicare.

ACKNOWLEDGMENT OF RELEASE

The undersigned has read the Compromise and Release, and understands its contents.

Applicant: _____

Date: 05/07/18

Applicant's Attorney: _____

Date: 5/7/18

For Defendants:  _____

Date: 5/8/2018