FORM CS-339-B

Send Original and 5 copies to
Court of Existing Claims

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

COMPROMISE SETTLEMENT — SECTION 339(B) WC Code

Agreement Between Employer and Employee As To Fact With Relation to an Injury and Payment of Compensation

(Please type or Print ALL information legibly in ink)

Claimant's Full Name (Injured Employee)	
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____	
Name of Employer	WCC File No.
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured	Date of Injury

This agreement is prepared and submitted pursuant to Section 339(B) of the Workers' Compensation Code, Title 85 of the Oklahoma Statutes. By signing below, each party affirms that they have read and understand its provisions, declares under penalty of perjury that all statements are true and accurate to the best of their knowledge and belief, and understands that the agreement, if approved by the Court of Existing Claims, is conclusive, final and binding on all the parties involved; PROVIDED, HOWEVER, IF A CHANGE IN CONDITION OCCURS, THIS AGREEMENT SHALL NOT BE FINAL, BUT MAY BE REOPENED AND REVIEWED AS PROVIDED BY LAW. ***Any person who commits worker's compensation fraud, upon conviction, shall be guilty of a felony.***

1. It is hereby agreed by and between the above named parties that the claimant sustained a compensable accidental injury on or about _____, _____, at (time) _____ , while in the employ of the employer, causing the following injury *(describe nature of the injury)*_____ , and resulting in **temporary total disability** from _____, _____ to_____, _____, or for a period of _____ weeks, _____ days, for which the claimant received $_____ in compensation from the employer/insurance carrier. The claimant's average weekly wage before the injury entitles the claimant to a compensation rate of $_____ for Temporary Total Disability and $_____ for Permanent Partial Disability/Permanent Partial Impairment.
2. It is further agreed that the claimant timely notified the employer, the claimant's employment was covered by the workers' compensation laws of the state, and this Court has jurisdiction in the matter.
3. As a result of the injury, the employer/carrier agrees to pay the claimant the sum of $_____ , same being for **permanent partial disability/permanent partial impairment** (_____%) to_____ _____, and the employer has furnished claimant all reasonable and necessary medical services in the treatment of the injury.
4. The sum of $_____ shall be deducted from this settlement and paid to the claimant's attorney pursuant to the workers' compensation laws of the state.
5. ***For Social Security offset purposes, and if applicable,*** *the claimant agrees to accept and the employer/carrier agrees to pay a lump sum of $_____ for permanent impairment that will affect the claimant for the rest of the claimant's life. The claimant's remaining life expectancy is _____ months. Therefore, even though paid in a lump sum, claimant's benefit (after deduction of attorney fees and expenses) shall be considered to be $_____ a month for _____ months, beginning _____, _____.*
6. THAT employer/carrier agrees to pay all applicable Court costs, and all taxes and assessments to the Oklahoma Tax Commission, as follows: $140.00 to the Workers' Compensation Court of Existing Claims, taxed as costs in this matter, unless previously paid; the Special Occupational Health and Safety tax in the sum of $_____, representing three-fourths of one percent (0.75%) of the compromise settlement amount, excluding medical payments and temporary total disability compensation; if a Court Approved OWN RISK employer or group self insurance association, "pursuant to 85 O.S. § 407, as amended by Laws 2013, HB 2201, c. 254, § 49, eff. January 1, 2015, Respondent, if Own Risk, shall pay $_____ to the Workers' Compensation Administration Fund created by 85 O.S. § 407, to be used for the costs of administering the Workers' Compensation Code as applicable to the Oklahoma Workers' Compensation Court of Existing Claims, representing two percent (2%) of the compromise settlement amount; and if UNINSURED, a Multiple Injury Trust Fund assessment in the sum of $_____, representing 5% of the compromise settlement amount.

CLAIMANT NAME — PLEASE PRINT	EMPLOYER NAME— PLEASE PRINT
CLAIMANT ADDRESS	NAME OF EMPLOYER'S CARRIER OR OWN RISK GROUP — PLEASE PRINT
CLAIMANT—SIGNATURE DATE	NAME OF EMPLOYER/CARRIER'S ATTORNEY — PLEASE PRINT OBA#
NAME OF CLAIMANT ATTORNEY — PLEASE PRINT OBA #	EMPLOYER/CARRIER ATTORNEY—SIGNATURE DATE
CLAIMANT ATTORNEY — SIGNATURE DATE	

ORDER APPROVING COMPROMISE SETTLEMENT (FORM CS-339-B)

The Court of Existing Claims, having reviewed the evidence submitted by the parties, approves the above Compromise Settlement, including attorney fees, which Compromise Settlement is incorporated herein and made a part hereof by reference.

If a child support lien was filed in this workers' compensation case, the employer/carrier shall include the name of the person or government agency asserting the lien on any check for benefits to the claimant in excess of One Thousand Dollars ($1,000.00).

The employer/carrier shall comply with this order within twenty (20) days from the file-stamped date of the order.

DONE this _____ day of _____, _____.

BY ORDER OF _____

JUDGE OR COURT ADMINISTRATOR

A copy hereof was mailed by United Stated regular mail on this file-stamped date to all attorneys of record and to unrepresented parties.