FORM 110-F
FATALITY
October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
657 Chamberlin Avenue, Frankfort, KY 40601

AGREEMENT AS TO COMPENSATION AND ORDER APPROVING SETTLEMENT

Workers' Compensation Claim No. ____________________

IF THIS FORM IS NOT PROPERLY COMPLETED, THE SETTLEMENT WILL NOT BE APPROVED.
Every section should be filled in. If a section is not applicable, fill in the blank with N/A.

Decedent/Employee

Plaintiff

Relationship to Decedent/Employee

Social Security Number/Green Card of Decedent/Employee

Date of Birth of Decedent/Employee

Mailing Address of Plaintiff

City, State, Postal Code of Plaintiff

Insurer/Self-Insured/Self-Insurance Group

Insurer's Mailing Address

City, State, Postal Code

Defendant/Employer

Mailing Address

City, State, Postal Code

Other Participating Parties

Mailing Address

City, State, Postal Code

INJURY

Date of Injury: ____________________ Date of Death: _________________________________

Address in which injury/fatality occurred:

Brief description of occurrence resulting in injury/fatality:

Nature of injury(ies) including body part(s) affected:

MEDICAL INFORMATION

Medical expenses paid: $_________________

Medical expenses unpaid or contested: $____________________ Date of last medical payment: ________________

WORK INFORMATION

Type of work at time of injury: __________________________________

Average weekly wage at time of injury: $__________________________

BENEFIT AND SETTLEMENT INFORMATION

Amount and duration of temporary total disability paid to date: $_______ X __________ = $__________
$ per week   No. of weeks   Total

If death occurs within four (4) years of the injury, has a lump sum payment been made to decedent's estate per KRS 342.750(6)? ☐ Yes ☐ No Amount: $_______________

Monetary terms of settlement: $________, to be paid as follows:________________________

Weekly for ____# weeks (if applicable)

Total settlement amount: $__________________

Settlement computation: ____

Proceeds of the settlement are allocated among qualifying dependents as follows:

Name	Date of Birth	Social Security Number/Green Card	Relationship to Decedent	Mailing Address	Weekly Benefit	Duration

Relationship of plaintiff (party signing settlement agreement) to decedent's/employee's minor dependents:
____

Is decedent/employee survived by any minor dependents other than those listed above? ☐ Yes ☐ No
If so, please list below:

Name	Mailing Address, City, State, Postal Code	Date of Birth	Guardian/Custodial

ATTACHMENTS

Please attach certified copies of the following documents:

1. Death Certificate
2. Marriage License
3. Birth certificates of minor dependents

OTHER INFORMATION

If additional information is pertinent to settlement, explain, (Attach additional pages if necessary):

____

Other responsible parties against whom further proceedings are reserved:

____

This the __________ day of ______________, 20___.

______________________________	______________________________
Attorney for Plaintiff Signature	Plaintiff Signature
______________________________	______________________________
Attorney for Plaintiff Name Typed	Attorney or representative for Defendant/Employer Signature
______________________________	______________________________
Mailing Address	Mailing Address
______________________________	______________________________
City, State, Postal Code	City, State, Postal Code
______________________________	______________________________
Telephone Number	Telephone Number