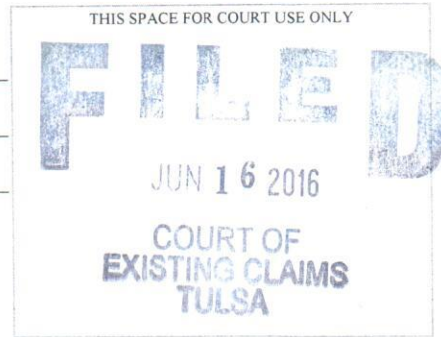


FORM CS-339-A

Send original and 5 copies to the Court of Existing Claims

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



In re Claim of: (Please type or Print ALL information legibly)

Claimant's Full Name (Injured Employee) Daniel Haas
Injured Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-7552
Name of Employer City of Broken Arrow
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured Own Risk #14157

WCC File Number 2014-05469A
Date of Injury 1/30/2014

Any person who commits worker's compensation fraud, upon conviction, shall be guilty of a felony.

Claim #: 444907552

COMPROMISE SETTLEMENT - Section 339(A) WC Code

This agreement is prepared and submitted pursuant to Section 339(A) 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 Workers' Compensation Court, is conclusive, final and binding on all the parties involved.

By this agreement, the parties settle upon and determine (check one):

[] ALL ISSUES AND MATTERS IN THE CLAIM (Settlement and Resolution of Claim With Full Release)

- 1. It is hereby agreed by and between the above named parties that the claimant alleges to have sustained a compensable accidental injury on or about 1/30/2014, while in the employ of the employer, causing the following injury (describe nature of injury) low back, and resulting in temporary total disability from ... to ... or for a period of ... weeks, ... days, for which the claimant received \$ All Paid in compensation from the employer/insurance carrier.
2. A claim for compensation was filed by the claimant for the injury, or, if the claimant is not represented by an attorney, an Employer's First Notice of Injury (Form 2) was filed by the employer for the injury, and the Workers' Compensation Court has jurisdiction in this matter.
3. This is an agreement in which the claimant agrees to accept \$ 11,426.29 in full and final settlement of all claims for: (describe injury) low back and any known or unknown body parts related to the injury on 1/30/2014 sustained as a result of the accident referred to above, including any claim by the claimant for past, present and future compensation for temporary total disability, temporary partial disability, permanent partial impairment or permanent total disability, statutory medical treatment, physical and vocational rehabilitation benefits, or loss of wage earning capacity, as a result of any and all injuries sustained in the accident.
4. 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.
5. The sum of \$ 2285.00 shall be deducted from this settlement and paid to the claimant's attorney pursuant to the workers' compensation laws of the state.
6. The 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, taxed as costs in this matter, unless previously paid; the Special Occupational Health and Safety Tax in the sum of \$ 85.70, 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 \$ 228.53 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.

Daniel Haas
CLAIMANT NAME - PLEASE PRINT
13909 South 299th Avenue, Coweta, OK 74429
CLAIMANT ADDRESS
CLAIMANT - SIGNATURE DATE
Esther M. Sanders
NAME OF CLAIMANT ATTORNEY - PLEASE PRINT OBA #
Esther M Sanders 6-16-16
CLAIMANT ATTORNEY - SIGNATURE DATE

City of Broken Arrow
EMPLOYER NAME - PLEASE PRINT
Leah P Keele 15483
NAME OF EMPLOYER/CARRIER'S ATTORNEY - PLEASE PRINT OBA #
Own Risk #14157
NAME OF EMPLOYER'S CARRIER OR OWN RISK GROUP - PLEASE PRINT
EMPLOYER/CARRIER ATTORNEY - SIGNATURE DATE
6-16-16

ORDER APPROVING COMPROMISE SETTLEMENT (FORM CS-339-A): The Workers' Compensation Court, having reviewed the evidence, files and records in this matter and being fully advised in the premises, approves the above Compromise Settlement, including attorney fees and the attached appendix to the Compromise Settlement, if any, which Compromise Settlement and appendix are incorporated herein by reference and made a part hereof. 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. In that event, and if the Compromise Settlement determined all issues and matters in the claim, this cause shall be fully and finally closed and resolved, and the Court divested of further jurisdiction therein.

DONE this _____ day of _____

Reporter's Initials

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

BY ORDER OF [Signature]
JUDGE OR COURT ADMINISTRATOR
Rev 2/19/15

BEFORE THE COURT OF EXISTING CLAIMS OF THE
STATE OF OKLAHOMA

FILED
JUN 16 2016

COURT OF
EXISTING CLAIMS
TULSA

Daniel Haas)
)
 Claimant,)
) Case No.: 2014-05469A
 vs.)
)
 City of Broken Arrow) SSN: XXX-XX-7552
)
 Respondent,)
)
 Own Risk #14157)
)
 Insurance Carrier.)

CERTIFICATE TO COMPROMISE SETTLEMENT


1. The Claimant certifies that the Respondent has been notified of all medical providers who have provided medical treatment, including physical therapy, as a result of the accidental injury while employed by Respondent. A list of all medical providers who have provided treatment is attached hereto as Exhibit A.

Further, the Claimant represents and agrees to notify all future medical providers for the accidental injury while employed by the Respondent that the claim against the Respondent has been fully settled by Compromise Settlement.



Daniel Haas
Claimant

2. The Respondent's attorney certifies that a copy of the Compromise Settlement will be provided to all known medical providers, including physical therapists, who have provided treatment to the Claimant, within ten (10) days of the settlement. The Respondent's attorney shall also notify the medical providers that the Compromise Settlement specifies that the Respondent will not be responsible for treatment rendered after the date of the Compromise Settlement.



Leah P Keele, OBA #15483
Attorney for Respondent

EXHIBIT "A" TO CERTIFICATE TO COMPROMISE SETTLEMENT

The following medical providers have provided medical treatment, including physical therapy, as a result of the accidental injury while employed by Respondent:

NAME	ADDRESS, CITY, STATE ZIP
Dr. Gillock	
Dr. Gaede	