

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

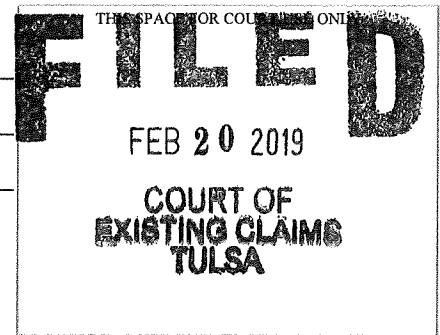
In re Claim of: (Please type or Print ALL information legibly).

Claimant's Full Name (Injured Employee) Kevin Dale Smith
Injured Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-99059905
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
2013-10642HDate of Injury
11/11/2011

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

Claim #: 446769905



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)

☐ SOME, BUT NOT ALL, ISSUES AND MATTERS IN THE CLAIM — Attach appendix of all outstanding issues. The appendix is subject to approval by the Workers' Compensation Court. It MUST accompany the Form CS 339-A, and be dated and signed by all parties under penalty of perjury.

- 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 11/11/2011, while in the employ of the employer, causing the following injury (*describe nature of injury*) Low Back, and resulting in temporary total disability from None, injury leave, or for a period of _____ weeks, _____ days, for which the claimant received All Paid in compensation from the employer/insurance carrier. The claimant's average weekly wage before the injury entitles the claimant to a compensation rate of \$735.00 for Temporary Total Disability and \$323.00 for Permanent Partial Disability/Permanent Partial Impairment.
- 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.
- This is an agreement in which the claimant agrees to accept \$ 45,000.00 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 11/11/2011 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. This sum is in addition to any previous amount(s) paid to the claimant, and any amount(s) for authorized, reasonable and necessary medical and rehabilitative expenses previously incurred by the claimant due to the injury. Of said sum, \$ 45,000.00 shall be paid for permanent partial disability/permanent partial impairment (28 %) to Low Back and \$ _____ shall be paid for _____. Settlement includes payment of any unpaid requests for reimbursements of mileage, prescriptions, or other out of pocket expenses.
- 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 _____.
- The sum of \$ 9,000.00 shall be deducted from this settlement and paid to the claimant's attorney pursuant to the workers' compensation laws of the state.
- 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 \$ 337.50, 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 \$ 900.00 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.

Kevin Dale Smith

CLAIMANT NAME - PLEASE PRINT

19710 E. 50th Pl. South, Broken Arrow, Ok 74014

CLAIMANT ADDRESS

CLAIMANT - SIGNATURE

RandaH Gill

NAME OF CLAIMANT ATTORNEY - PLEASE PRINT

CLAIMANT ATTORNEY - SIGNATURE

DATE

10/30/19

OBA #

2/20/19

DATE

City of Broken Arrow

EMPLOYER NAME - PLEASE PRINT

Kymberly J Watt

15797

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

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 _____, 2019.

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

Rev 2/19/15

JUDGE OR COURT ADMINISTRATOR

FILED
FEB 20 2019

FEB 20 2019

**COURT OF
EXISTING CLAIMS
TULSA**

Case No.: 2013-10642H

SSN: XXX-XX-9905

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:

[illegible]

Mandatory Medicare Reporting/Child Support Lien Requirement

***** Please complete this form with each report of injury*****

Medicare now requires mandatory reporting of Workers' Compensation claims. The purpose of the reporting process is to enable Centers for Medicare & Medicaid Services (CMS) to correctly pay for the health insurance of Medicare beneficiaries by determining primary versus secondary payer.

To be completed by the employee (Please print)

Date: 2/20/19

Injured Worker Name: KEVIN DALE Smith
(Name as it appears on your social security card)

Social Security Number: XXX-XX- 9905 Date of Birth 10/17/64

Dear Injured Worker, please provide an answer to the following questions:

YES	NO	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Are you currently on SSDI? (Social Security Disability)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you ever applied for SSDI?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you anticipate filing for SSDI within the next 30 months?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Are you a Medicare beneficiary?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Have you or are you currently participating in a Medicare Advantage Plan? (This is a Medicare supplement product purchased from a private carrier such as Humana, Blue Cross Blue Shield etc.)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	If so, name of Carrier: _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you anticipate filing for Medicare benefits in the next 30 months?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	If you are on Medicare, What is your Medicare Beneficiary Identifier Number (MBI)? _____
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Are you in End Stage Renal Disease?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Do you have a Child Support Lien against you? If so, which State? _____

KD Smith
Signature of Injured Worker

2/20/19
Date

PLEASE FORWARD THE COMPLETED FORM TO:

LATHAM, WAGNER, STEELE & LEHMAN, PC
10441 S Regal Blvd., Ste. 200
Tulsa, Oklahoma 74133
918.970.2000 telephone
918.970.2002 facsimile