FORM CS-339-A
Send original and 5 copies to the Court of Existing Claims

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

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

THIS SPACE FOR COURT USE ONLY

FILED
FEB 20 2019
COURT OF EXISTING CLAIMS
TULSA

Claimant's Full Name (Injured Employee) **Kevin Dale Smith**	WCC File Number **2013-10642H**
Injured Employee's Social Security Number (LAST 4 DIGITS ONLY) **XXX-XX-99059905**	Date of Injury **11/11/2011**
Name of Employer **City of Broken Arrow**	**Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.**
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured **Own Risk #14157**	**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.

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 **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.
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 $ 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.**
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. 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 __ , _____.*
5. 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.
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 $ 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 — DATE

Randall Gill — 10309
NAME OF CLAIMANT ATTORNEY - PLEASE PRINT — OBA #

2/20/19
CLIAMANT ATTORNEY - SIGNATURE — 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 _____
JUDGE OR COURT ADMINISTRATOR

Rev 2/19/15

BEFORE THE COURT OF EXISTING CLAIMS OF THE STATE OF OKLAHOMA

Kevin Dale Smith	)	
	)	
Claimant,	)	
	)	**Case No.: 2013-10642H**
vs.	)	
	)	
City of Broken Arrow	)	**SSN: XXX-XX-9905**
	)	
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.

Kevin Dale Smith
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.

Kymberly J Watt, OBA #15797
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	7170 S. Braden Ave., Tulsa, OK
Dr. Marouk	2128 South Atlanta Place, Tulsa, OK
Dr. D. Hawkins	6585 South Yale, Suite 200, Tulsa, OK
Dr. Hauger	6600 S. Yale Avenue, Suite 600, Tulsa, OK
Dr. Anthony	6802 S. Olympia Ave., Ste. 100, Tulsa, OK

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	
	✓	**Are you currently on SSDI? (Social Security Disability)**
	✓	**Have you ever applied for SSDI?**
	✓	**Do you anticipate filing for SSDI within the next 30 months?**
	✓	**Are you a Medicare beneficiary?**
	✓	**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.) **If so, name of Carrier: _____**
	✓	**Do you anticipate filing for Medicare benefits in the next 30 months?**
	✓	**If you are on Medicare, What is your Medicare Beneficiary Identifier Number (MBI)?_____**
	✓	**Are you in End Stage Renal Disease?**
	✓	**Do you have a Child Support Lien against you? If so, which State?_____**

K D H 2/20/19

Signature of Injured Worker 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*