

SAMPLE CLAIMS DISPOSITION AGREEMENT

A sample Claims Disposition Agreement follows. See also the [Oregon Workers' Compensation Board](#) website for active bulletins and additional information on Claim Disposition Agreements and any related informational enclosures.

IMPORTANT NOTICES

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**BEFORE THE WORKERS' COMPENSATION BOARD
FOR THE STATE OF OREGON**

IN THE MATTER OF THE COMPENSATION)	CDA No.:
	)	WCB No.:
	)	WCD No.:
	)	Claim No.:
OF	)	D.O.I.:
	)	Employer:
	)	Insurer:
	)	Administrator:
WORKER'S NAME,)	
	)	CLAIM DISPOSITION AGREEMENT
Claimant.	)	PURSUANT TO ORS 656.236
	)	AND OAR 438-009-0022

TYPE OF RELEASE

ISSUE/BENEFIT RELEASED

Full **Partial**

___	___	Temporary Disability
___	___	Permanent Disability
___	___	Vocational Assistance
___	___	Survivor's Benefits
___	___	All Workers' Compensation rights and benefits under ORS Chapter 656 except to the extent claimant may be entitled to ORS 656.245 medical services and preferred worker status.

AMOUNT OF DISPOSITION

\$ Total Due Attorney (subject to WCB approval)
\$ Total Due Claimant

METHOD OF PAYMENT (check one)

___ Lump Sum
___ Structured Settlement
___ Both of the Above

WAIVER OF "30-DAY" PERIOD

___ YES ___ NO

1. Claimant's name and address: _____
2. Employer's name and address: _____
3. Insurer's/Administrator's name and address: _____
4. Claimant's attorney's name and address: _____
5. Employer's/Insurer's/Administrator's attorney's name and address: _____
_____.
6. The accepted condition(s) subject to this claim disposition agreement is/are _____
_____.
7. This claim was first closed on _____ (date).
8. The total amount (percent) of permanent disability benefits awarded on the claim is _____ percent permanent partial disability.
9. The worker has/has not been able to return to the work force following the industrial injury or occupational disease.
10. The worker's age is ____ years and his/her highest educational level is _____.
The extent of vocational training (or, if the worker is deceased, the age, highest education level, and the extent of vocational training of the worker's beneficiaries) is/are: _____.
11. The following is a list of occupations that the worker has performed (or, if the worker is deceased, a list of occupations that each of the deceased worker's beneficiaries has performed): _____.
12. Pursuant to ORS 656.236, in consideration of the payment of \$_____ by the insurer/employer, claimant releases his/her right to the following workers' compensation benefits for claimant's life: temporary disability, permanent disability, vocational assessment and rehabilitation benefits, survivor's benefits, Board's Own Motion benefits, aggravation benefits, consequential condition claim benefits, expanded scope of acceptance claim benefits, omitted condition claim benefits, new condition claim benefits, death and burial benefits, ORS 656.262(11) and ORS 656.382 penalties and fees and all other workers' compensation benefits however construed and/or established, except ORS 656.245 medical service related benefits and preferred worker status to the extent claimant may be so entitled, and penalties and attorney fees related to untimely payment of these settlement proceeds.

The insurer's/employer's obligation to provide these benefits for claimant's life is also released. The parties expressly agree that any and all conditions accepted at any time in this claim are contemplated and encompassed by and subject to this Claim Disposition Agreement. The parties expressly agree that the insurer/employer preserves its rights to the following: third party rights under this claim, including the entitlement to recovery of its statutory third party lien pursuant to ORS 656.576 through ORS 656.596, if any; recovery and recoupment of benefits, offsets or overpaid compensation; its civil remedies, administrative remedies and/or any other remedies, including for recovery of

benefits paid due to fraud or misrepresentation. This disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of the accepted claim for all conditions accepted in the claim at any time and for claim processing at any time, except in relation to issues of and for compensable ORS 656.245 medical services arising after the date of receipt of this agreement by the Board, and penalties and attorney fees related to untimely payment of these settlement proceeds.

13. Out of the above consideration, an attorney fee of \$_____ shall be paid as a reasonable attorney fee.
 - a. The attorney fee does not exceed the Board's rule (OAR 438-015-0052), and there are no extraordinary circumstances that justify an extraordinary fee.
 - b. The agreement is not to be paid in installments, and there is no cost of an annuity. The present value of the agreement is as previously stated herein.
14. Claimant retains his/her right to ORS 656.245 medical service-related benefits for the compensable injury and his/her right for preferred worker status.
15. Claimant was given a written informational enclosure, separate from the agreement, in the form prescribed by the Board pursuant to OAR 438-009-0022. By their signatures below, claimant and claimant's attorney verify that claimant has read the written informational enclosure and this Claim Disposition Agreement or that claimant has had them comprehensively read to claimant in their entirety and that claimant understands the contents of the written informational enclosure and this Claim Disposition Agreement.

NOTICE TO CLAIMANT: UNLESS YOU ARE REPRESENTED BY AN ATTORNEY AND YOUR CLAIM DISPOSITION AGREEMENT INCLUDES A PROVISION WHICH WAIVES THE 30-DAY "COOLING OFF" PERIOD, YOU WILL RECEIVE A NOTICE FROM THE WORKERS' COMPENSATION BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT TELLING YOU THE DATE THIS AGREEMENT WAS RECEIVED BY THEM FOR APPROVAL. YOU HAVE 30 DAYS FROM THE DATE THE BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT RECEIVES THE AGREEMENT TO REJECT THE AGREEMENT, BY TELLING THE BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT IN WRITING. DURING THE 30 DAYS ALL OTHER PROCEEDINGS AND PAYMENT OBLIGATIONS OF THE INSURER/SELF-INSURED EMPLOYER, EXCEPT FOR MEDICAL SERVICES, ARE STAYED ON YOUR CLAIM. IF YOU DO NOT HAVE AN ATTORNEY, YOU MAY DISCUSS THIS AGREEMENT WITH THE BOARD IN PERSON WITHOUT FEE OR CHARGE. TO CONTACT THE BOARD, WRITE OR CALL: WORKERS' COMPENSATION BOARD, 2610 25TH ST. SE, STE 150, SALEM, OREGON 97302-1280, TELEPHONE: (503) 378-3308, TOLL-FREE AT 1-877-311-8061, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.

YOU MAY ALSO DISCUSS THIS AGREEMENT WITH THE OMBUDSMAN FOR INJURED WORKERS, WITHOUT FEE OR CHARGE. TO CONTACT THE OMBUDSMAN, WRITE OR CALL: OMBUDSMAN FOR INJURED WORKERS, LABOR & INDUSTRIES BUILDING, 350 WINTER STREE NE, SALEM, OR 97310, TELEPHONE: (503) 378-3351, TOLL-FREE AT 1-800-927-1271, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.

YOU MAY ALSO CALL THE WORKERS' COMPENSATION DIVISION'S INJURED WORKER HOTLINE, TOLL-FREE IN OREGON, AT 1-800-452-0288.

16. Payment of the disposition shall be made no later than the 14th day (or as otherwise specified herein) after notice of the Board's approval or the administrative law judge who mediated the agreement's approval has been mailed or distributed to the parties or their representatives under OAR 438-009-0030(5) and (6) by means of an order, posting on WCB's website, electronic distribution through WCB's website portal, or postcard. See OAR 438-009-0028; OAR 438-009-0030(7).
17. On Board approval of this agreement or on approval of the administrative law judge who mediated the agreement, the following requests for hearing/review shall be dismissed: WCB Case No.: _____.
18. Claimant acknowledges that he/she has reviewed the description of benefits, as described in this agreement and the informational enclosure prescribed in OAR 438-009-0022, and has had opportunity to ask questions of his/her attorney or the insurer/employer to further understand the consequences of signing this agreement.
19. Claimant is represented by an attorney and parties agree to waive the "30 day" waiting period under ORS 656.236(1)(a)(C) for Board approval of this agreement.

IT IS SO STIPULATED AND AGREED.

[Typed Name], Claimant Date

[Typed Name], Attorney for Claimant Date

[Typed Name], Attorney for Insurer/Employer Date

THIS AGREEMENT IS IN ACCORDANCE WITH THE TERMS AND CONDITIONS PRESCRIBED BY THE WORKERS' COMPENSATION BOARD. SEE ORS 656.236(1). ACCORDINGLY, THIS CLAIM DISPOSITION AGREEMENT IS APPROVED. AN ATTORNEY FEE PAYABLE TO CLAIMANT'S ATTORNEY ACCORDING TO THE TERMS OF THIS AGREEMENT IS ALSO APPROVED.

IT IS SO ORDERED.

DATED THIS _____ DAY OF _____, 20__.

Board Member or Administrative Law Judge Who Mediated the Agreement

Board Member

NOTICE TO ALL PARTIES: THIS ORDER IS FINAL AND IS NOT SUBJECT TO REVIEW. ORS 656.236(2).