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PETITION FOR BENEFIT DETERMINATION
SETTLEMENT APPROVAL ONLY
Tennessee Bureau of Workers' Compensation
Court of Workers' Compensation Claims
tn.gov/workerscomp

Applies to injuries on or after July 1, 2014

A) **DATE of INJURY**_____ Employee's Social Security Number: _____

DESCRIPTION of INJURY_____

B) Was this case mediated by Mediation and Ombudsman Services of Tennessee? **Yes   No**

C) Does this Settlement represent the <u>closure of medical coverage</u>? **Yes   No**   If "**Yes,**" Date of Initial Settlement_____

D) Does this Settlement represent the <u>increased benefits from a prior settlement?</u> **Yes   No**   If "**Yes,**" Date of Initial Settlement_____

E) **EMPLOYEE'S NAME**:_____DATE of BIRTH_____/_____/_____

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

EMPLOYEE'S ATTORNEY:_____BPR NO.:_____

PHONE NO.:_____FAX NO.:_____EMAIL:_____

Does employee require an interpreter? **Yes   No**   If "**Yes,**" language_____dialect_____

Please complete and attach **Addendum to Petition for Benefit Determination for Death Claims Only**.

F) **EMPLOYER'S NAME**: _____Contact Person:_____

EMPLOYER'S ATTORNEY:_____BPR NO.:_____

PHONE NO.:_____FAX NO.:_____EMAIL:_____

G) **INSURANCE CARRIER**: _____ CLAIM NO.:_____

THIRD PARTY ADMINISTRATOR:_____ ADJUSTER'S NAME:_____

PHONE NO.:_____FAX NO.:_____EMAIL:_____

DATES REQUESTED for APPROVAL: _____/_____/_____
(If required by regional office)

BY SIGNATURE BELOW, THE PARTIES REQUEST THAT THE COURT OF WORKERS' COMPENSATION CLAIMS REVIEW AND APPROVE THE PROPOSED SETTLEMENT AGREEMENT, HEREBY SUBMITTED ALONG WITH ALL SUPPORTING DOCUMENTS.

_____
Employee or Employee's Representative (Signature)

_____
Employer or Employer's Representative (Signature)