FORM CS-339-A

Send original and 5 copies to the Court of Existing Claims.

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

THIS SPACE FOR COURT USE ONLY

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

Claimant 's Full Name (Injured Employee)	WCC File Number
Injured Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX- _____	Date of Injury
Name of Employer	
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured	

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

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 Court of Existing Claims, 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 _____, _____, while in the employ of the employer, causing the following injury *(describe nature of injury)* _____ _____, and resulting in **temporary total disability** from _____, _____ to _____, _____ or for a period of _____weeks, _____ days, for which the claimant received $_____in compensation from the employer/insurance carrier. The claimant's average weekly wage before the injury entitles the claimant to a compensation rate of $_____ for Temporary Total Disability and $_____ 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 Court of Existing Claims has jurisdiction in this matter.
3. This is an agreement in which the claimant agrees to accept $_____ in full and final settlement of all claims for: *(describe injury)* _____ _____ 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, $_____ shall be paid for permanent partial disability/permanent partial impairment (_____%) to _____ _____ and $_____ shall be paid for _____.
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 $_____ shall be deducted from this settlement and paid to the claimant's attorney pursuant to the workers' compensation laws of the state.
6. THAT 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 of Existing Claims, taxed as costs in this matter, unless previously paid; the Special Occupational Health and Safety tax in the sum of $_____, 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 $_____ 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.

CLAIMANT NAME — PLEASE PRINT	EMPLOYER NAME— PLEASE PRINT
CLAIMANT ADDRESS	NAME OF EMPLOYER/CARRIER'S ATTORNEY — PLEASE PRINT OBA#
CLAIMANT—SIGNATURE DATE	NAME OF EMPLOYER'S CARRIER OR OWN RISK GROUP — PLEASE PRINT
NAME OF CLAIMANT ATTORNEY — PLEASE PRINT OBA #	EMPLOYER/CARRIER ATTORNEY—SIGNATURE DATE
CLAIMANT ATTORNEY — SIGNATURE DATE	

ORDER APPROVING COMPROMISE SETTLEMENT (FORM CS-339-A): The Court of Existing Claims, 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 _____, _____.

BY ORDER OF _____
JUDGE OR COURT ADMINISTRATOR

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.