Filed Date Stamp Here

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

For BWC Use Only

Docket No._____
State File No./YR_____
RFA No._____
Date of Injury: _____

Prior PBD Filed: ☐ Yes ☐ No

Assigned Judge_____

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 closure of medical coverage? **Yes** ☐ **No** ☐ If "**Yes,**" Date of Initial Settlement_____

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

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

MAILING ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

COUNTY.:_____PHONE NO.:_____EMAIL:_____

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: _____ / _____ / _____

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.

(If required by regional office)

_____ Employee or Employee's Representative (Signature)

_____ Employer or Employer's Representative (Signature)