ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act ☒ Occupational Diseases Act ☐ Fatal case? No ☒ Yes ☐ Date of death _____

Frank Arnold
Employee/Petitioner

Case # **24** WC **013000**

v.

City of Collinsville
Employer/Respondent

Setting **Collinsville, IL**

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Frank Arnold [redacted]
Employee's name Street address City, State, Zip code

City of Collinsville **125 South Center Street, Collinsville, IL 62234**
Employer's name Street address City, State, Zip code

State Employee? Yes ☐ No ☒ Male ☒ Female ☐ Married ☒ Single ☐

Dependents under age [redacted] Birthdate [redacted] Average weekly wage $ **2,327.52**

Date of accident **04/11/2024**

How did the accident occur? [redacted]

What part of the body was affected? [redacted]

What is the nature of the injury? [redacted]

The employer was notified of the accident orally ☒ in writing ☒ Return-to-work date **04/12/2024.**

Location of accident **Collinsville, IL** Did the employee return to his or her regular job? Yes ☐ No ☒
If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

[redacted]

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for **Nil** weeks at the rate of $ **N/A**/week.

The employee was temporarily totally disabled from **In dispute** through **In dispute** .

MEDICAL EXPENSES: The employer has ☒ has not ☐ paid all medical bills. List unpaid bills in the space below.

Respondent has not paid any benefits under the Act on this claim and has denied any responsibility under the Act for any benefits, including medical care.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner $ **0** as compensation for the permanent disability caused by this injury.

An arbitrator or commissioner of the Commission previously made an award on this case on **N/A** regarding

TTD $ **0** Permanent disability $ **0** Medical expenses $ **0** Other $ **0**

TERMS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee.
Respondent to pay and Petitioner to accept the sum of $12,000.00 in full and final settlement of all issues arising out of the accidental injury sustained [redacted]

Petitioner asserts that he is not currently a Medicare Beneficiary, has not applied for any Social Security Disability Benefits or other benefits to which he might be entitled to Medicare or Medicaid benefits, that none of his medical bills in connection with care and treatment for this event were submitted to Medicare/Medicaid for payment and that he is not likely to become a Medicare/Medicaid recipient within the next 30 months. [redacted] The parties acknowledge and agree that they have taken into account the future interest of Medicare/Medicaid in the resolution of this case and that they find that no provision need be made for the establishment of any Medicare Set Aside Trust Fund.

Total amount of settlement	$ **12,000.00**
Deduction: Attorney's fees	$ _____
Deduction: Medical reports, X-rays	$ _____
Deduction: Other (explain)	$ _____
Amount employee will receive	$ _____

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.*
I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

_____	**Frank Arnold**	[redacted]	_____
Signature of petitioner	Name of petitioner (please print)	Telephone number	Date

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

_____ _____
Signature of attorney Date

Richard Volpe (00728)
Attorney's name and IC code # (please print)

Law Offices of Thomas Duda, a Division of Disparti Law Group
Firm name

330 West Colfax
Street address

Palatine, IL 60067
City, State, Zip code

847-577-2470 **richard@zipduda.com**
Telephone number E-mail address

RESPONDENT'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

_____ _____
Signature of attorney or agent Date

Rodney W. Thompson (#810)
Attorney's name and IC code # or agent (please print)

Becker, Hoerner & Ysursa, P.C.
Firm name

5111 West Main Street
Street address

Belleville, IL 62226
City, State, Zip code

618-235-0020 **rwt@bhylaw.com**
Telephone number E-mail address

IPMG
Name of respondent's insurance or service company (please print)

ORDER OF ARBITRATOR OR COMMISSIONER:
Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case.