

**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 _____

Mike Jeffries
Employee/Petitioner

Case # **24** WC **029308**

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.

Mike Jeffries
Employee's name

Street address _____ City, State, Zip code _____

City of Collinsville
Employer's name

125 South Center Street, Collinsville, IL 62234
Street address _____ City, State, Zip code _____

State Employee? Yes No Male Female Married Single

Dependents under age 18 **0** Birthdate _____ Average weekly wage \$ **1,629.93**

Date of accident **04/02/2024**

How did the accident occur? **Petitioner was moving a heavy manhole cover.**

What part of the body was affected? _____

What is the nature of the injury? _____

The employer was notified of the accident orally in writing Return-to-work date **04/03/2024**

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.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for **0** weeks at the rate of \$ **N/A**/week.

The employee was temporarily totally disabled from **N/A** through **N/A**.

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

Employer insurer have paid or will pay any and all reasonable and necessary services related to the event of 04/02/2024 in accordance with the terms and provisions of the Illinois Workers' Compensation Act and the Medical Fee Schedule therein.

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 \$67,234.75 in full and final settlement of all issues arising out of the accidental injury sustained on or about 04/02/2024 and any aggravating incidents occurring thereafter in Petitioner's employment with Respondent to the date of the signing of this contract with regard to Petitioner's

[redacted] of this extent of permanent disability and future medical treatment, if any. It is the purpose of this contract to effect a full and final settlement of all issues existing between the parties under the Illinois Workers' Compensation Act including, but not limited to, the right of either party to review or reopen this case under Sections 8(a) and 19(h). This contract does not, however, extinguish any rights that the Respondent may have under the Act and in accordance with the provisions of Section 5 (820 ILCS 305/5).

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. Petitioner also asserts that he is not currently undergoing any care or treatment for the injuries he sustained on 04/02/2024 and that no further treatment has been recommended to him by any physician or other medical provider. 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 \$ **67,234.75**
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.

Signature of petitioner **Mike Jeffries** Name of petitioner (please print) [redacted] 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.

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 **David M. Galanti (04463)** Date
Attorney's name and IC code # (please print)

Signature of attorney or agent **Rodney W. Thompson (#810)** Date
Attorney's name and IC code # or agent (please print)

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618-235-0020 **rwt@bhyllaw.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.