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 _____

Jason W. Warner
Employee/Petitioner

Case # **15** WC **028128**

v.

City of Collinsville
Employer/Respondent

Setting **Collinsville – Arbitrator Rowe-Sullivan**

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.

Employee's name	Street address	City, State, Zip code
Jason W. Warner	[redacted]	
Employer's name	Street address	City, State, Zip code
City of Collinsville	**125 South Center Street,**	**Collinsville, Illinois 62234**

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

Dependents under age 18 [redacted] Birthdate [redacted] Average weekly wage $ **1,515.36**

Date of accident **8/11/2015**

How did the accident occur? **Petitioner was moving patient on a stretcher.**

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 **9/8/15**

Location of accident **Collinsville** 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 **21-2/7** weeks at the rate of $ **1,010.24 – TTD $482.38 - TPD**/week.

The employee was temporarily totally disabled from **8/11/15** through **1/8/16**.

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

Employer and insurer have paid, or will pay, any and all reasonable, necessary and related medical services provided by Dr. George Paletta. Employer and Insurer have paid all medical bills that they believe are reasonable, necessary and related to Petitioner's injury of 8/11/15 to the various medical providers at Multi-Care Specialists, Granite City, Illinois and will not be responsible for any alleged outstanding balances through that medical facility or any of its practitioners.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner $ **0.00** 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 $ **0.00** Permanent disability $ **0.00** Medical expenses $ **0.00** Other $ **0.00**

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 $33,437.37 in full and final settlement of all issues arising out of the accidental injuries sustained on or about 8/11/15 and any aggravating incidents occurring thereafter in Petitioner's employment with the Respondent through November 8,2016, with regard to Petitioner's [redacted] and is to be paid in a lump sum upon approval of this contract. Disputes exist between the parties as to the nature and extent of permanent disability, responsibility for certain medical expenses incurred through the date of the signing of this contract and the need for 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 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. The Petitioner also asserts that he is not currently undergoing any care or treatment for the injuries he sustained on 8/11/15 and that no further treatment has been recommended to him by any physician. The parties acknowledge and agree that they have taken into account the future interests 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	$ 33,437.37
Deduction: Attorney's fees	$ 6,185.91
Deduction: Medical reports, X-rays	$ 0.00
Deduction: Other (explain)	$ 186.33 (Hospital records)
Amount employee will receive	$ 27,065.13

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.

[redacted] Jason W. Warner 618-539-0657 11/21/16
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.

[redacted] 11/22/16
Signature of attorney | Date

Craig Millman (728)
Attorney's name and IC code # (please print)

Law Offices of Thomas W. Duda
Firm name TIN #36-3312933

330 West Colfax Street
Street address

Palatine, Illinois 60067
City, State, Zip code

847-577-2470 christina@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, [redacted] of the approved contract.

[redacted] 11/29/16
Signature of attorney or agent | Date

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

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

5111 West Main Street
Street address

Belleville, Illinois 62226
City, State, Zip code

(618) 235-0020 rwt@bhtylaw.com
Telephone number | E-mail address

Corporate Claims Management, Inc.
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.