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PETITION FOR BENEFIT DETERMINATION SETTLEMENT APPROVAL ONLY

Tennessee Bureau of Workers' Compensation
Court of Workers' Compensation Claims
www.tn.gov/workforce/section/injuries-at-work

Applies to injuries on or after July 1, 2014

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: _____

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:_____

EMPLOYEE'S ATTORNEY:_____ BPR NO.:_____

PHONE NO.:_____ FAX NO.:_____ EMAIL:_____

F) EMPLOYER'S NAME: _____ Contact Person:_____

EMPLOYER'S ATTORNEY:_____ BPR NO.:_____

PHONE NO.:_____ FAX NO.:_____ EMAIL:_____

G) INSURANCE CARRIER: _____

THIRD PARTY ADMINISTRATOR:_____ CLAIM NO.:_____

ADJUSTER'S NAME:_____

PHONE NO.:_____ FAX NO.:_____ EMAIL:_____

DATES REQUESTED for APPROVAL: _____ / _____ / _____
(If required by regional office)

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.

_____ Employee or Employee's Representative (Signature)

_____ Employer or Employer's Representative (Signature)