FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

2 N. Charles Street, Baltimore, MD, 21201 / 410.752.8700 T / 410.752.6868 F / www.fandpnet.com

MARYLAND
Workers' Compensation
Key Forms and Dates

State of Maryland
Workers' Compensation Claims
Key Forms and Dates

ECF. AWW must be contested at the first hearing.

- If no evidence is presented in support of the Employer's proposed AWW, then the AWW stated on the ECF will govern
- A copy of the wage statement must be sent to the Claimant and his/her attorney in addition to the Commission
- Self-calculating form is available at the Commission website http://www.wcc.state.md.us/

7. Award of Compensation and Average Weekly Wage (Exhibit No. 7) 15
    - Form Award automatically issued when the consideration date for contesting the claim has passed and the contesting issues have **not** been filed
    - In an uncontested claim, the Award will reflect the AWW as alleged on ECF or the AWW supported by a timely filed Wage Statement
    - If you wish to dispute an "automatic" Award (i.e., you missed the consideration date), a Request for Rehearing must be filed within 15 days, or an appeal must be filed within 30 days, from the date of the Award
    - IMPORTANT – a Motion for Rehearing or Appeal does <u>not</u> "stay" an Award (i.e. you must pay benefits ordered while pursuing rehearing appeal).
    - Also referred to as a "Statistical Award"

8. Document Correction (C90R) (Exhibit No. 8) 16
    - This form is used to request a correction when the parties agree that there is a typographical or other error on a claim document or order

9. Standard Issues Form (H-24R) (Exhibit No. 9) 17
    - May be used by any party to file Issues which arise later in the Claim, such as nature and extent of permanent partial disability
    - May also be used by the Employer/Insurer to file contesting issues prior to the Claim's Consideration date, or to contest causal relationship at any time
    - Should not be used to seek/dispute vocational rehabilitation services

10. Notice of Issue (A-19D) (Exhibit No. 10) 18
    - This is an indication from the WCC that a party to the case has requested a hearing. Promptly check with WCC to confirm what Issues have been raised (if you did not receive a copy from Claimant's attorney)
    - Employer/Insurer **must** have attorney enter appearance within 15 days of Notice of Issues (or receive a "10 day letter" (Exhibit No. 11) from WCC)

11. 10 day Notice (Exhibit No. 11) 19
    - Within 10 days of the filing of issues, the insurer shall have an attorney enter his/her appearance in the claim
    - After an entry of appearance is received from an attorney on behalf of the insurer, then all papers filed on behalf of the insurer must be filed by the attorney until the claim becomes undisputed

12. Notice of Hearing (H-51D) (Exhibit No. 12) 20
    - Sent to all parties and counsel of record when the Commission has scheduled a Claim for Hearing

- Contains the names of all parties and counsel with the date, time and location of the Hearing

13. Request for Action on Filed Issues (H25R) (Exhibit No. 13) 21
    - This form is used to request a) withdrawal of issues if the parties have resolved the dispute and do not need an order, b) dismissal of the claim by the Claimant voluntarily, c) a change of the venue or location for the hearing, or d) a second claim with same Claimant and similar injury to be heard at the same time

14. Request for Continuance (H28R) (Exhibit No. 14) 22
    - This form enables a party to request a continuance or postponement of the hearing from the date indicated on the hearing notice
    - If a continuance is requested more than 30 days in advance of the hearing, then the consent of the opposing attorney is not required; however courtesy dictates that the parties seek consent for a continuance
    - If a continuance is requested less than 30 days in advance of the hearing, then consent must be requested
    - A continuance can still be requested even if consent is denied, but request must note the lack of consent

15. Sample Awards and Orders (Exhibit No. 15) 23
    - Mailed to all parties, generally within one or two weeks of the Hearing
    - States what Issues were considered by the Commission, and provides a ruling on each Issue
    - Generally a Permanent Partial Disability Award will reflect a specific percentage of disability found by the Commission with respect to each injured body part adjudicated
    - Payment of benefits allowed under the Award or Order must be issued commencing within 15 days of the date of the Order
    - Either party has the right to Petition for Judicial Review (appeal) an Order within 30 days of the date of the Order, but such a Petition does not stay the obligation to pay the benefits awarded

16. Notice of Termination of Indemnity Benefits (C-06) (Exhibit No. 16) 29
    - This form is utilized to unilaterally cut off Claimant's temporary total disability benefits based on evidence of return to work or MMI (or lack of medicals to support continued benefits)
        - Must file C-06 (with a copy mailed to the Claimant) with last compensation check, or you may have exposure for additional benefits

17. Notice of Termination of Medical Benefits (C-10) (Exhibit No.17) 30
    - This form is used to terminate medical treatment and payment of medical bill
    - Attach copy of medical report as basis for termination
        - Must file C-10 (with a copy mailed to Claimant, Claimant's attorney, and to Claimant's treating physicians)

18. Agreement on Vocational Counselor (VR06) (Exhibit No. 18) 31
    - The parties must use this form to notify the WCC of the agreed upon vocational counselor for the claim. If the parties cannot agree then the WCC becomes the arbiter and selects the counselor

19. Vocational Rehabilitation Plan (VR01) (Exhibit No. 19) 32
    - Filed when all parties agree on a plan for vocational rehabilitation

20. Disagreement with Proposed Vocational Rehabilitation Plan (VR13R) (Exhibit No. 20) 37
    - If either parties does not agree with the vocational plan developed by the counselor this form enables a hearing on the issue to address the concern

21. Stipulation (H-34) (Exhibit No. 21) 38
    - Avoids hearing, but does <u>not</u> close any aspect of claim
    - Generally used in lieu of a permanency hearing for a certainty as to the amount of benefits to be paid
    - As there will be no hearing, you will not have a transcript of complaints if the claim is later reopened
    - WCC will issue an Award based on stipulation (i.e. an agreement between the parties)

22. Agreement of Final Compromise and Settlement ("full and final") and Required Documents (Exhibit No. 22) 40
    - Can have a "full and final" settlement, with or without "closed medicals," but must be approved by WCC by Order
    - Specified supporting documentation (e.g. Affidavit and Settlement Worksheet) must be included (usually prepared by Claimant's attorney)
    - Beware of accepting open ended "and payment of medicals to date of settlement" language in AFCS
    - Settlement terms must take Medicare's interests into account.
    - Unlike Stipulation, a full and final settlement forever closes all aspects of claim once approved by WCC
    - Sample Order approving settlement
    - Caveat: The sample settlement agreement provided is not for use without consultation with counsel.

23. Request for Employer Designee to Receive Notice of Employee Claims (H-23R) (Exhibit No. 23) 46
    - Allows Employer to have a second person or company keeping an eye out for new claims, issues, and hearing notices so that nothing is missed

Exhibit 1

WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

EMPLOYER (NAME & ADDRESS INCL ZIP)
Name
Address
City State MD
Zip -
INDUSTRY CODE
EMPLOYER FEIN

CARRIER/ADMINISTRATOR CLAIM | OSHA LOG | REPORT PURPOSE
JURISDICTION | JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # ( ) -
Address
City State MD Zip - | PHONE # ( ) -

CARRIER (NAME, ADDRESS, & PHONE #)
Name
Address
City State MD
Zip - Phone ( ) -
CARRIER FEIN
POLICY/SELF-INSURED NUMBER

POLICY PERIOD
/ /
TO
/ /
CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Name
Address
City State MD
Zip - Phone ( ) -
ADMINISTRATOR FEIN

EMPLOYEE Last Name | Middle
First Name
Address
City State MD
Zip - Phone ( ) -
OF DEPENDENTS

DATE OF BIRTH / /
SOCIAL SECURITY - -
DATE HIRED / /
STATE OF HIRE MD
SEX
◯ Male ◯ Female ◯ Unknown
MARITAL STATUS
◯ Unmarried Single/Divorced ◯ Married ◯ Separated ◯ Unknown
OCCUPATION/JOB TITLE
EMPLOYMENT STATUS
Full-Time
NCCI CLASS CODE

WAGE RATE PER: ◯ Day ◯ Week ◯ Month ◯ Other
DAYS WORKED/WEEK 5
FULL PAY FOR DAY OF INJURY? ◯ Yes ◯ No
DID SALARY CONTINUE? ◯ Yes ◯ No

TIME EMPLOYEE BEGAN : ◯ AM ◯ PM
DATE OF INJURY/ILLNESS / /
TIME OF OCCURRENCE : ◯ AM ◯ PM ◯ Unknown
LAST WORK DATE / /
DATE EMPLOYER NOTIFIED / /
DATE DISABILITY BEGAN / /

CONTACT NAME | CONTACT PHONE ( ) - | TYPE OF INJURY/ILLNESS | PART OF BODY AFFECTED

DID INJURY/ILLNESS/EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ◯ Yes ◯ No
TYPE OF INJURY/ILLNESS CODE | PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE
ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED
WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL
CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK / /
IF FATAL, GIVE DATE OF DEATH / /
WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? ◯ Yes ◯ No
WERE THEY USED? ◯ Yes ◯ No

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)
Name
Address
City State MD -

HOSPITAL OR OFF SITE TREATMENT (NAME & ADDRESS)
Name
Address
City State MD -

INITIAL TREATMENT
◯ NO MEDICAL TREATMENT
◯ MINOR BY EMPLOYER
◯ MINOR CLINIC/HOSP
◯ EMERGENCY CARE
◯ HOSPITALIZED > 24 HOURS
◯ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

WITNESS NAME | PHONE ( ) -
ADMINISTRATOR NOTIFIED / /
DATE PREPARED 03/29/2017
PREPARER'S NAME & TITLE
PHONE NUMBER ( ) -
PREPARER'S EMAIL ID:

FORM IA-1(r 1-1-02) IAIABC 2002

WCC Web Form IA-1

EMPLOYER'S INSTRUCTIONS

DO NOT ENTER DATA IN SHADED FIELDS UNLESS APPROPRIATE

DATES:

Enter all dates in MM/DD/YY format. Enter all time in HH:MM format (e.g. 06:05)

INDUSTRY CODE:

This is the code which represents the nature of the employer's business, which is contained in the Standard Industrial Classification Manual or the North American Industry Classification System, published by the Federal Office of Management and Budget.

CARRIER:

The licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer of the claimant.

CLAIMS ADMINISTRATOR:

Enter the name of the carrier, third party administrator, state fund, or self-insured responsible for administering the claim.

AGENT NAME & CODE NUMBER:

Enter the name of your insurance agent and his/her code number if known. This information can be found on your insurance policy.

OCCUPATION/JOB TITLE:

This is the primary occupation of the claimant at the time of the accident or exposure.

EMPLOYMENT STATUS:

Indicate the employee's work status. The valid choices are:

Full-Time	On Strike	Unknown	Volunteer
Part-Time	Disabled	Apprenticeship Full-Time	Seasonal
Not Employed	Retired	Apprenticeship Part-Time	Piece Worker

DATE DISABILITY BEGAN:

The first day on which the claimant originally lost time from work due to the occupation injury or disease or as otherwise designated by statute.

CONTACT NAME/PHONE NUMBER:

Enter the name of the individual at the employer's premises to be contacted for additional information.

TYPE OF INJURY/ILLNESS:

Briefly describe the nature of the injury or illness, (eg. Lacerations to the forearm).

PART OF BODY AFFECTED:

Indicate the part of body affected by the injury/illness, (eg. Right forearm, lower back).

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Maintenance Department or Client's office at 452 Monroe St., Washington, DC 26210)

If the accident or illness exposure did not occur on the employer's premises, enter address or location. Be specific.

EMPLOYER'S INSTRUCTIONS – cont'd

ALL EQUIPMENT, MATERIAL OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Acetylene cutting torch, metal plate)

List all of the equipment, materials, and/or chemicals the employee was using, applying, handling or operating when the injury or illness occurred. Be specific, for example: decorator's scaffolding, electric sander, paintbrush, and paint.

Enter "NA" for not applicable if no equipment, materials, or chemicals were being used. NOTE: The items listed do not have to be directly involved in the employee's injury or illness.

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

(eg. Cutting metal plate for flooring)

Describe the specific activity the employee was engaged in when the accident or illness exposure occurred, such as sanding ceiling woodwork in preparation for painting.

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED:

Describe the work process the employee was engaged in when the accident or illness exposure occurred, such as building maintenance. Enter "NA" for not applicable if employee was not engaged in a work process (eg. walking along a hallway).

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL:

(Worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

Describe how the injury or illness/abnormal health condition occurred. Include the sequence of events and name any objects or substance that directly injured the employee or made the employee ill. For example: Worker stepped to the edge of the scaffolding to inspect work, lost balance and fell six feet to the floor. The worker's right wrist was broken in the fall.

DATE RETURN(ED) TO WORK:

Enter the date following to most recent disability period on which the employee returned to work.

DATE OF DEATH (if applicable)

This is a required field. Enter the date of death, if applicable.

TYPE OF INJURY/ILLNESS CODE

This is a required filed. Enter the two-digit code that corresponds to the type of injury/illness. A list of codes can be found at:

INITIAL TREATMENT

This is a required field. Select the item that corresponds to the initial treatment.

Exhibit 2

EMPLOYEE'S CLAIM

WORKERS' COMPENSATION COMMISSION
10 East Baltimore Street
Baltimore, Maryland 21202-1641

BALTIMORE PHONE 410-864-5100
TOLL FREE 1-800-492-0479 IN MARYLAND
TTY USERS CALL VIA MARYLAND RELAY

CLAIM NUMBER:

1. Claimant First Name
2. Middle Initial
3. Claimant Last Name
4. Phone Number ( ) -
5. Street Address
6. City
7. County
8. State MD
9. Zip Code
10. Social Security Number - -
11. Sex ☐ M ☐ F
12. Date of Birth / /
13. Marital Status ☐ M ☐ S
14. Gross Wages Per Week $.
15. Paid full wages for day? ☐ YES ☐ NO
16. What Is Your Regular Work?
17. What Was Your Work When Injured?

18. Full and correct business name of your employer
19. Employer Phone Number ( ) -
20. Complete Address
21. City
22. State MD
23. Zip Code
24. Notice of Injury Given? ☐ YES ☐ NO
25. Nature of Employer's business
26. Location where accident occurred
27. Whom did you notify of the accident?
28. First Day Not Worked / /
29. Occupational Disease? ☐ YES ☐ NO
30. Date of accident/occupational disease disablement / / AM ☐ PM ☐ Time
31. Describe how accidental injury occurred

OR

32. Describe how occupational disease occurred

NOTE: Failure to disclose information or giving false information, including information regarding any work related activity or return to work either before or after an award of benefits, may subject you to fines, imprisonment, or both, and disqualify you from receiving benefits. A CLAIMANT'S FAILURE TO COMPLETE THIS FORM IN COMPLIANCE WITH THE DIRECTIONS ON PAGE 3 MAY RESULT IN THE CLAIM BEING REJECTED. TO EXPEDITE YOUR CLAIM, YOU MAY SEND A COPY OF THE COMPLETED FORM TO YOUR EMPLOYER.

33. What member of your body was injured?
34. Amputation required? ☐ YES ☐ NO
35. Employer requested to provide medical care? ☐ YES ☐ NO
36. Medical care provided? ☐ YES ☐ NO
37. Date returned to Work / /
38. Attending Physician Name
39. Street Address
40. Apt. / Suite
41. City
42. State MD
43. Zip Code
44. If you were in a hospital -- Hospital Name
45. Street Address
46. Apt. / Suite
47. City
48. State MD
49. Zip Code
50. If Health Insurance used, give name of Insurance Co.

I hereby make claim for compensation for an injury resulting in my disability due to an accident (or disease) arising out of and in the course of my employment, and in support of it make the foregoing statement of facts. I hereby certify that the information I have given is accurate and that I have read the information on this form.

SIGNATURE: _____

DATE: _____

Email

Received:

E10227966

MARYLAND WORKERS' COMPENSATION COMMISSION
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Pursuant to Labor and Employment Article, §§ 9-709, 9-710, and 9-711, Annotated Code of Maryland, this authorization must be signed and filed with the Workers' Compensation Commission of Maryland in conjunction with any claim for workers' compensation benefits.

A. Person Covered by Authorization

This document authorizes the disclosure of protected health information regarding:

Name/Claimant / / Date of Birth

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. Entities Authorized to Make Disclosure

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of my protected health information to the following entities and their agents: my attorney, my employer, and my employer's workers' compensation insurer.

E. Information to be Disclosed

This document authorizes the entities listed in C to disclose protected health information that is relevant to:

1. The member of the body that was injured as indicated on the claim application form. (see box 33)
2. The description of how the accidental injury occurred as indicated on the claim application form. (see box 31)
3. The description of how the occupational disease occurred as indicated on the claim application form. (see box 32)

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date the claim is filed.

_____ _____

Patient/Claimant Signature Date

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.

IMPORTANT: It is the Claimant's responsibility to maintain a current mailing address with the Commission. The Commission Claim Number should be included on all correspondence.

Disclosure Pursuant to COMAR 01.01.1983.18

1. The personal information requested on this form is intended to be used in processing your claim under the Maryland workers' compensation laws.
2. Failure to provide the information requested may result in your claim being rejected or a delay in the processing of your claim.
3. You may have a right to inspect, amend and correct the information provided on this form pursuant to State Government Article, §10-624, Maryland Code Annotated.
4. This form will be made part of your claim file. Portions of your claim file may be subject to public inspection.
5. The information contained on this form is routinely shared with State, Federal or local agencies.

Claim Filing Instructions

This form may not be submitted as a photocopy or recreated on office systems. Any such claim will be returned to the sender without processing the claim. The Commission does not accept any claim forms, documents or claim-related information via facsimile (FAX) or email.

1. **This online Employee Claim Form C-1 MUST be completed online using Formatta Filler. The form is completed on your PC using your keyboard to enter the form field information.**
2. Provide the requested information in each numbered section.
3. Dates must be filled in MMDDYYYY (month-day-year) format.
4. When information is not available, zeros MUST be entered. For example, Social Security Number: 000000000 (9 zeros). Gross Wages should be entered with no dollar sign or decimal point. For example, $112.51 is entered as 11215, or if unknown or not available, all zeros.
5. Entries cannot exceed the length of the indicated field. If the information is longer than the field allows, please abbreviate WITHOUT punctuation.
6. DO NOT use letters, spaces or symbols in fields requiring such information as telephone number or Social Security number.
7. If there is insufficient space on the claim form, please attach additional pages with a paper clip. Number the item to correspond to the form field number, e.g. #15.
8. DO NOT cross out, staple, tape or use correction fluid or tape (White-Out) on the form. Do not alter the printed form. WebForms that are handwritten, typed or altered will be returned to the sender without processing.
9. A claim submission that does not include the claimant's name, address, date of accident or occupational disease, date of birth, the member of the body that was injured, a description of how the accidental injury or occupational disease occurred, or sufficient information to process the claim may be rejected and returned to the claimant.
10. Enter your email address at the bottom of the form when submitting the form to receive a confirmation email and additional information.
11. **To submit the completed claim form click the SUBMIT button. The SUBMIT button will send form data to the WCC and prompt you to PRINT THE FORM and SAVE THE FORM.**
12. **Print the claim form when prompted. Sign and date the claim form** in dark or black ink. DO NOT use a permanent marker or other instrument that bleeds through the paper.
13. **Read, sign and date the Authorization for Disclosure of Health Information.**
14. **Mail or hand deliver the signed claim form and Authorization for Disclosure of Health Information to the Commission as soon as possible, but no later than 10 days after submitting the claim form online.**
15. A claim form that does not include the signed Authorization for Disclosure of Health Information will be rejected and returned to the claimant.
16. A claim is considered filed on the date that a completed and signed claim form, including the signed Authorization for Disclosure of Health Information, is received by the Commission. The Commission's date of receipt is determined by the date stamp affixed on the claim form.
17. You can confirm your claim filing via the Public Claim Data Inquiry located in the PUBLIC ONLINE SERVICES menu.
18. Submit only one claim form; filing duplicates will delay claim processing.

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN UNNECESSARY DELAY OR RETURN FOR CORRECTION AND RESUBMISSION OF THE CLAIM FORM.

WCC COUNTY CODES TO COMPLETE THE CLAIM FORM

Allegany - AL	Charles - CH	Prince George's - PG
Anne Arundel - AA	Dorchester - DR	Queen Anne's - QA
Baltimore - BA	Frederick - FR	Saint Mary's - SM
Baltimore City - BC	Garrett - GA	Somerset - SO
Calvert - CT	Harford - HA	Talbot - TA
Caroline - CA	Howard - HO	Washington - WA
Carroll - CL	Kent - KT	Wicomico - WI
Cecil - CE	Montgomery - MT	Worcester - WO

Exhibit 3

WCC FORM C-30D(REV:04/05)

NOTICE OF EMPLOYEE`S CLAIM

Claim Number:

Workers` Compensation Commission 10 E. Baltimore St., Baltimore, MD 21202-1641
Telephone (410)864-5100 Toll Free Phone 1-800-492-0479 in Md.

DATE: 11/30/2016

Claimant Information | Claimant Phone # | Claimant Attorney

SS#	Date of Birth	Sex	Marital Status	Regular Work
		M	S	TOWING

Gross Weekly Wages	Paid Day of Accident	Work When Injured	Person Notified of Accident
500.00	N	TOWING	

Employer Information | Employer Phone # | Nature of Business: TOWING

Location of Accident: TRUCK BED | Notified: Y

Accident Date: 11/14/2016 O/D Date Disablement: | 1st Day unable to work: 11/15/2016

Description of Accident or How Occupational Disease Occurred:
WHILE UP ON HIS TOW TRUCK BED, CLAIMANT SLIPPED ON OIL AND FELL BACKWARDS, ONTO HIS BACK.

Member Injured/Amputation:
BACK, HEAD, RIGHT WRIST, NECK

Medical Requested: Y Provided: Y Date Returned: Other Claim #:

Physician Information
MULTI-SPECIALTY
2511 EDISON HIGHWAY
BALTIMORE, MD 21213

Hospital Information
GOOD SAMARITAN HOSP.
5601 LOCHRAVEN BLVD
BALTIMORE, MD 21239

Insurer Information | Insurer Attorney

Date Received: 11/22/2016 Date Mailed: 11/30/2016 Consideration Date: 12/21/2016

Exhibit 4

WCC FORM C40-D(REV:02/10)

WORKERS' COMPENSATION COMMISSION

10 EAST BALTIMORE ST., BALTIMORE, MD. 21202-1641

This form is to be used for requested information only. Do not add additional information.

This document must be completed and returned by the consideration date

Claim Number

Employee

Insurer

Employer

Date claim received 11/22/2016

Adjuster _____ (PLEASE PRINT)

Date of Accident 11/14/2016

Consideration Date 12/21/2016

Date mailed to insurer 11/30/2016

INSURER CODE

Adjuster Phone No. _____ (PLEASE PRINT)

[ ] The insurer commenced temporary total disability payments on _____.
in the amount of _____ per week.

[ ] The first payment of temporary total was mailed to the claimant on_____.

[ ] No compensable lost time.

[ ] The insurer raises contesting issues as indicated below.

_____ _____
Signature Date

CONTESTING ISSUES

[ ] Did the employee sustain an accidental personal injury or occupational disease arising out of and in the course of employment?

[ ] Is the disability of the employee the result of an accidental personal injury or occupational disease arising out of and in the course of employment?

[ ] Did the employee sustain a compensable hernia within the meaning of the Compensation Act?

[ ] Other _____

_____

This form completed and signed must be received by the Commission on or before the consideration date.

The filing of these contesting issues does not relieve you of the responsibility of serving issues on the other parties of interest.

This is to certify that a copy of the above issues has been served upon all parties.

this _____ day of _____ 20___

_____

Signature of party raising these issues

WORKERS' COMPENSATION COMMISSION

10 EAST BALTIMORE ST., BALTIMORE, MD 21202-1641

This form is to be used for requested information only. Do not add additional information.
This document must be completed and returned by the consideration date.

Claim Number:		**Date of Accident:**	**11/14/2016**
Employee:		**Consideration Date:**	**12/21/2016**
Insurer:		**Date mailed to Insurer:**	**11/30/2016**
Employer:		**INSURER CODE:**	
Date claim received:			
Adjuster:		**Adjuster's Phone No.:**	

☐ The insurer commenced temporary total disability payments on _____ in the amount of _____ per week.

☐ The first payment of temporary total was mailed to the claimant on _____

☐ No compensable lost time.

■ The insurer raises contesting issues as indicated below.

CONTESTING ISSUES

■ Did the employee sustain an accidental personal injury or occupational disease arising out of and in the course of employment?

■ Is the disability of the employee the result of an accidental personal injury or occupational disease arising out of and in the course of employment?

☐ Did the employee sustain a compensable hernia within the meaning of the Compensation Act?

■ Other **AWW and any other issues that may arise at time of hearing.**

This form completed and signed must be received by the Commission on or before the consideration date.

The filing of these contesting issues does not relieve you of the responsibility of serving issues on the other parties of interest.

This is to certify that a copy of the above issues has been served upon all parties

this **14th** day of **December** , **2016**

Received:

Filed By:

WCC Web Form C-40 D

Exhibit 5

WORKERS' COMPENSATION COMMISSION

CLAIM AMENDMENT

Instructions: This form must be completed in its entirety and be signed by the claimant.

Claimant's Name: _____
First Middle Last

_____ _____
WCC Claim Number **Date**

Claimant's Address: _____

City _____ State _____ ZIP Code _____

Employer/Insurer: _____

On _____ (Date) I, _____ (Claimant's Name),
filed a claim for compensation for an injury or occupational disease to the following body members (Form C-1, Box 33):

I wish to amend my claim for compensation to add the following body member(s):

I wish to amend my claim for compensation to remove the following body member(s):

I hereby amend my claim for compensation and certify that the foregoing facts are true and accurate.

_____ _____
Claimant's Signature **Date**

Certificate of Service

I hereby certify that on this day of _____, 2_____, I mailed, postage prepaid, a copy of the foregoing "Claim Amendment" and "Authorization for Disclosure of Health Information" to all parties.

_____ _____
Signature **Date**

10 East Baltimore Street W Baltimore, Maryland 21202-1641
410-864-5100 W Email: info@wcc.state.md.us W Web: http://www.wcc.state.md.us

CLAIM AMENDMENT AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Pursuant to Labor and Employment Article, §§ 9-709, Annotated Code of Maryland, and COMAR 14.09.01.06, this authorization must be signed and filed with the Workers' Compensation Commission of Maryland in conjunction with any claim amendment form.

A. Person Covered by Authorization

This document authorizes the disclosure of protected health information regarding:

Name/Claimant _____ Date of Birth _____

WCC Claim Number _____

B. Purpose of Disclosure

This document authorizes the disclosure of protected health information for the purpose of processing, adjudicating and resolving workers' compensation claims.

C. Entities Authorized to Make Disclosure

This document authorizes any health plan, physician, health care professional, dentist, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my protected health information consistent with this directive.

D. Entities Authorized to Receive Protected Health Information

This document authorizes the disclosure of my protected health information to the following entities and their agents: my attorney, my employer, and my employer's workers' compensation insurer.

E. Information to be Disclosed

This document authorizes the entities listed in C to disclose protected health information that is relevant to the member of the body that was injured as indicated on the claim amendment form.

The protected health information that may be disclosed includes, but is not limited to: history, findings, office and patient charts, files, examination and progress notes, and physical evidence.

F. I understand that I may revoke this authorization by giving written notice to all parties to my claim for workers' compensation, except to the extent that this authorization has already been acted on prior to receipt of my revocation.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient to a medical manager, health care professional or registered rehabilitation practitioner, and others consistent with state and federal law.

By signing this form, I am authorizing the disclosure of my protected health information. This authorization is valid for one year from the date the claim amendment is filed.

Patient/Claimant Signature _____ Date _____

A photocopy, facsimile or electronic transmission of this signed authorization form is valid.

CLAIM AMENDMENT

IMPORTANT: It is the Claimant's responsibility to maintain a current mailing address with the Commission. The Commission Claim Number should be included on all correspondence.

Disclosure Pursuant to COMAR 01.01.1983.18

1. The personal information requested on this form is intended to be used in processing your claim under the Maryland workers' compensation laws.
2. Failure to provide the information requested may result in your claim being rejected or a delay in the processing of your claim.
3. You may have a right to inspect, amend and correct the information provided on this form pursuant to State Government Article, §10-624, Maryland Code Annotated.
4. This form will be made part of your claim file. Portions of your claim file may be subject to public inspection.
5. The information contained on this form is routinely shared with State, Federal or local agencies.

Claim Filing Instructions

The Claim Amendment form must be used in order to amend a claim and add or delete a body part. This form may be downloaded from the Commission's website at the web address below. The Commission does not accept any claim forms, documents or claim-related information via facsimile (FAX) or email.

1. All entries MUST be hand written or typed. If hand written, print as clearly as possible in DARK OR BLACK INK.

2. Please provide all requested information in each space.

3. Dates should be filled in MM/DD/YYYY (month-day-year) format. "Leading zeros" must be entered with single digit numbers, for example, January 5, 1999 must be entered as 01/05/1999.

4. When information is not available, zeros MUST be entered. For example, Social Security Number: 000000000 (9 zeros.

5. Entries MUST NOT exceed the length of the indicated field. If the information is longer than the field allows, please abbreviate WITHOUT punctuation.

6. IF THERE IS NOT ENOUGH SPACE ON THE CLAIM FORM, PLEASE ATTACH ADDITIONAL PAGES WITH A PAPER CLIP. PLEASE NUMBER THE ITEMS THAT ARE BEING ADDED.

7. Please DO NOT cross out, staple, tape or use correction fluid or tape (White-Out) on the form.

8. A Claim Amendment form that does not contain the claimant's name, claim number, date of filing of original claim, the original member(s) of the body injured, the member(s) of the body that are to be added or removed, or sufficient information to process the claim may be rejected and returned to the claimant.

9. **Sign and date the Claim Amendment form.**

10. **Read, sign and date the Claim Amendment Authorization for Disclosure of Health Information.**

11. **A CLAIM AMENDMENT FORM THAT DOES NOT INCLUDE A SIGNED AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION WILL BE REJECTED AND RETURNED TO THE CLAIMANT.**

FAILURE TO FOLLOW THESE INSTRUCTIONS MAY RESULT IN THE REJECTION OF THE CLAIM AMENDMENT FORM.

FOR MORE INFORMATION, VISIT:
http://www.wcc.state.md.us

Exhibit 6

WORKERS' COMPENSATION COMMISSION

STATEMENT OF WAGE INFORMATION

The information below is provided pursuant to LE, §9-602(a)(2), Annotated Code of Maryland and COMAR 14.09.03.06.
This form should be submitted before the consideration date or to provide updated wage information.

Claimant Name _____

WCC Claim Number _____

*****Was this employee provided free rent, lodging, board, tips or other allowances in addition to the above earnings?
If "yes", the weekly or bi-weekly value must be included in the "Other Allowances" Column.

When the employee is paid weekly, complete each row for the most recent 14 weeks where wages were paid. If paid alternate weeks please enter in the clear, even-numbered rows. If paid on any other schedule, please use the worksheet on page 2 to calculate the average weekly wage. If less than 14 weeks were worked by the employee, use the worksheet on page 2.

Week #	Week Ending (MM/DD/YYYY)	Days Worked	Gross Wages *including overtime*	Other Allowances*	Total Amount Paid
1					0.00
2					0.00
3					0.00
4					0.00
5					0.00
6					0.00
7					0.00
8					0.00
9					0.00
10					0.00
11					0.00
12					0.00
13					0.00
14					0.00
TOTALS		0	0.00	0.00	0.00

TOTAL	0.00	**divided by number weeks worked (where wages are paid/indicated)**	**14**	=	**Average Weekly Wage**	$0.00

I HEREBY CERTIFY that on this_____day of_____,_____, service of the foregoing was made in accordance with COMAR 14.09.01.03.

SUBMITTED BY:

Name Signature

Company Title

Street

City State ZIP Code

Telephone Email address

STATEMENT OF WAGE INFORMATION

CALCULATION OF AVERAGE WEEKLY WAGE WHEN CLAIMANT IS PAID OTHER THAN WEEKLY OR BI-WEEKLY

(Monthly, Semi-Monthly or other, attach details)

A. Inclusive dates used in wage statement _____ to _____

B. Number of days used in calculation
(Minimum 98 days to capture 14 weeks)

C. Gross wages
(including overtime, free rent, lodging, board, tips & other allowances)

D. Daily Rate (**C ÷ B**) Calculate

Average Weekly Wage (**D x 7**) $0.00

Exhibit 7

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE ST., BALTIMORE, MD 21202-1641

Claim No.
Employee
Employer
Insurer

AWARD OF COMPENSATION
AND AVERAGE WEEKLY WAGE

After due consideration of the above entitled case, it is determined that the claimant sustained an accidental injury or occupational disease/illness as defined in Section 9-101 (b) or (g), Labor and Employment Article, Maryland Annotated Code, arising out of and in the course of employment on 1/23/2016 that the average weekly wage was $451.03 and that the claimant was temporarily totally disabled as a result of said injuries.

The Commission has concluded to pass an ORDER based on the evidence in the record, but will reserve the right of both parties to have the issue of average weekly wage Adjudicated at the first hearing before the Commission.

It is, therefore, this day 10/07/2016 by the Workers' Compensation Commission **ORDERED** that the said employer and insurer:

1. Pay unto the said claimant compensation at the rate of $301.00 per week, payable weekly, during the continuance of the temporary total disability of the claimant. Said compensation to begin on 1/27/2016 provided, however, that the injury results in disability of more than 14 days, compensation shall be paid from the date of the disability including the day the injury occurred; subject to a credit for the days the claimant worked and received wages.
2. Promptly provide said claimant medical treatment and the other necessary medical services as provided by Section 9-101 (b) or (g), Labor and Employment Article, Maryland Annotated Code.
3. When the claimant receives medical care from a physician of his or her selection, he or she shall provide medical reports and invoices to the insurer.

This Award is subject to further determination by this Commission as to whether or not the claimant has sustained any permanent disability.

ATTEST:

SECRETARY TO THE COMMISSION

CHAIRMAN

10/07/2016

Exhibit 8

WORKERS' COMPENSATION COMMISSION

REQUEST FOR DOCUMENT CORRECTION

INSTRUCTIONS: This form is to be used by a party **ONLY** to notify the Commission that an undisputed factual error exists in a document that has been filed in a specific workers' compensation claim. The mistake may be an error in the document as originally submitted, or may be due to human or technological error. Any party identifying an error on a document in the Commission's files (paper or electronic) should complete this form and submit it to the Commission for consideration. The form should be submitted without a cover letter. For example, if all parties agree that the Date of Accident as originally submitted on a claim form is incorrect this form may be used to obtain a correction in the Commission's records. If, however, a factual dispute exists with respect to the Date of Accident and the party originally submitting the information believes it is factually accurate, the matter should not be categorized as a document correction. The dispute should be resolved at a hearing together with other matters upon which the parties do not agree.

THIS FORM MAY NOT BE USED TO ADD OR REMOVE A MEMBER OF THE BODY. The form ***Claim Amendment (C-3)*** must be used and includethe fully completed and executed Authoriation for Disclosure of Health Information (page 2).

An error has been identified in a claim document on file with the Workers' Compensation Commission as described below. This submission requests that corrective action be taken as soon as possible.

CLAIM NUMBER: _____ **CLAIMANT NAME:** _____

DOCUMENT TYPE: _____ **DOCUMENT DATE:** _____

ERROR DESCRIPTION:

CORRECTION REQUESTED:

REQUESTED BY:

◯ **CLAIMANT** ◯ **CLAIMANT'S ATTY** ◯ **EMPLOYER/INSURER** ◯ **EMP/INS** ◯ **OTHER:**

FULL NAME (PRINTED) _____ **SIGNATURE** _____ **DATE OF REQUEST** _____

Street Address _____ **City** _____ **State** _____ **ZIP Code** _____

Telephone _____ **Email Address** _____

10 East Baltimore Street W Baltimore, Maryland 21202-1641
410-864-5100 W Email: info@wcc.state.md.us W Web: http://www.wcc.state.md.us

Exhibit 9

WORKERS' COMPENSATION COMMISSION

ISSUES

Claim Number _____ Date _____

Claimant _____

Employer _____

Insurer _____

Healthcare Provider _____

The following issues are hereby raised by (choose one)

☐ Claimant/Attorney ☐ Non Insured/ Attorney ☐ SIF
☐ Employer/Attorney ☐ Healthcare Provider/Attorney ☐ UEF
☐ Insurer/Attorney

☐ 1. Did the employee sustain an injury causally related to an accident which arose out of and in the course of employment?
☐ 2. Is the disability of the employee (TT/TP/PT/PP) causally related to the accidental injury?
☐ 3. Did the employee sustain a compensable hernia within the meaning of the Workers' Compensation Act?
☐ 4. Did the employee sustain an occupational disease?
☐ 5. Average weekly wage
☐ 6. Limitations
☐ 7. Jurisdiction
☐ 8. Statutory employment
☐ 9. Medical expenses (creditors and/or amount)
☐ 10. Vocational rehabilitation
☐ 11. Attorney fees/costs
☐ 12. Penalties
☐ 13. Temporary total disability from _____ to _____
☐ 14. Nature and extent of permanent disability to the following part or parts of the body:

☐ 15. Other (specify)

☐ 16. Authorization for medical treatment (you must briefly specify treatment requested)

☐ 17. Temporary total from _____ to present and continuing.

I HEREBY CERTIFY that on this _____ day of _____, _____, service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03.

_____ _____
Name of Party Raising Issues Signature

Exhibit 10

WCC FORM A-19D(REV:01/08)

W O R K E R S ' C O M P E N S A T I O N C O M M I S S I O N
10 EAST BALTIMORE ST., BALTIMORE, MD. 21202-1641

Claim Number _____

Employee _____

Employer _____

Insurer _____

NOTICE OF ISSUE FILED

One or more issues have been filed with the Commission on 3/16/2011 as being in dispute between parties.

This Notice is provided for your information only at the present time. Unless the Commission is notified to withdraw the issue(s) or that the dispute has been otherwise resolved, a hearing will be scheduled in due course at which the parties may present matters for consideration by a Commissioner. As a party to this case, you will receive a written Notice of Hearing when the case has been scheduled. This notice will provide you with the time, date, and location of the hearing.

Exhibit 11

W O R K E R S' C O M P E N S A T I O N C O M M I S S I O N
10 East Baltimore Street
Baltimore, Maryland 21201-1641
410-864-5100 * Email: info@wcc.state.md.us * Web: www.wcc.state.md.us

DATE: 02/19/2015

INSURER/SELF-INSURED EMPLOYER: INSURANCE

INSURER/SELF-INSURED
EMPLOYER ADDRESS:

CLAIMANT'S NAME:

CLAIM NUMBER: W

Dear Insurer/Self-Insured Employer:

Pursuant to COMAR 14.09.01.23(b), within 15 days of the filing of issues by any party in a matter in which an attorney has not already entered an appearance on behalf of the insurer/self-insured employer, an insurer/self-insured employer shall have an attorney complete and file a Request to Enter Appearance of Counsel form with this Commission to establish an attorney of record. This form can be found on our website at www.wcc.state.md.us. An insurer/self-insured employer found to be in violation of this regulation may be fined up to $1,000.00 per offense.

Although you were previously notified by the Commission, to date, no attorney has filed a Request to Enter Appearance on your behalf.

Please be advised that if within 10 days from the date of this letter, you have not complied with COMAR 14.09.01.23(b), the Commission will issue a Show Cause Order and action will be taken against you.

Workers' Compensation Commission

CC: A L L P A R T I E S

Exhibit 12

WCC FORM H-51D(REV:03/12)

NOTICE OF HEARING

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE ST., BALTIMORE, MD. 21202-1641
http://www.wcc.state.md.us.

Claim Number: Date: 06/20/2016

Claimant

Clm. Atty.

Employer

Insurer

Ins. Atty.

******** NOTICE ********

This is a formal legal proceeding. Appropriate dress is required.
If this claim is on appeal, the parties shall be prepared to demonstrate that the Commission currently has jurisdiction over the issues upon which the hearing is set.
A party needing assistance for a witness with limited English proficiency should contact The Interpreter Program Office at (410)864-5299, within 10 days from the date the hearing notice is issued.
To find out if hearings at this location have been cancelled due to weather conditions or other emergency dial 410-864-5100 or toll-free 1-800-492-0479. TTY users call via Maryland Relay.

A HEARING ON THIS CASE WILL BE HELD: Date of Accident: 1/23/2016

Date: 8/05/2016
Time: 9:30

Place: HEARING SITE DOES NOT OPEN UNITL 8:00 AM
10 EAST BALTIMORE STREET-4TH FL
BALTIMORE, MD 212020000

Courtroom#: 444

ALL Hearings will be held on the 4th floor

Exhibit 13

WORKERS' COMPENSATION COMMISSION

REQUEST FOR ACTION ON FILED ISSUES

This form is to be used only for the actions identified below and is to be submitted without a cover letter.

WCC CLAIM NUMBER: _____

CLAIMANT'S NAME: _____

EMPLOYER: _____

INSURER: _____

HEALTHCARE PROVIDER: _____

If hearing has been scheduled: DATE _____ **LOCATION** _____

SELECT ONLY ONE ACTION:

◯ **Withdrawal of issues previously filed (Filing party only).**

◯ **Dismissal of claim (On behalf of claimant only).**

◯ **"Set With" scheduling:** _____

REQUIRED ITEMS:List ALL claims to be included. EACH claim listed MUST have Pending Issues AND a SEPARATE Set-With form (H25R) filed in EACH claim.

◯ **Change of Venue:**
Requestor MUST complete the Location and Date Information above

Requested Location: _____

Reason for Change: _____

REQUESTED BY:

◯ **Claimant** ◯ **Claimant'sAttorney** ◯ **Employer/Insurer** ◯ **Employer/InsurerAttorney** ◯ **SIF/UEF**

◯ **Healthcare Provider/Attorney**

CERTIFICATE OF SERVICE

I hereby certify that on this _____day of _____ , _____ , service of the foregoing and any attached documentation was made in accordance with COMAR 14.09.01.03 to all parties and their attorneys. Failure to notify opposing counsel prior to the hearing date may result in a penalty or fine to be assessed against a party withdrawing issues.

Address: _____ City: _____ State: ____ Zip Code: _____

Telephone: _____ Email: _____

_____ _____
Full Name **Signature**

Exhibit 14

REQUEST FOR CONTINUANCE OF HEARING

INSTRUCTIONS: The form is to be used only to request a continuance of a scheduled hearing, and is to be submitted without a cover letter.

REQUEST TO THE COMMISSION

The undersigned hereby requests that the hearing scheduled for the date and location described below be continued for the reason(s) specified.

Claimant _____ WCC Claim Number _____

Employer _____

Insurer _____

Currently Scheduled Hearing Information:

Hearing Date _____

Location _____

Date of Hearing Notice _____

Justification for Continuance:

I HEREBY CERTIFY that on this____day of_____,_____, service of the foregoing was made in accordance with COMAR 14.09.01.03. I further certify that the opposing counsel/ parties have been contacted and they: Select One

REQUESTED BY:

Claimant ☐ Claimant's Atty. ☐ Employer/Emp. Atty. ☐ Insurer Atty. ☐ UEF/SIF ☐

Address:_____City:_____State:_____Zip Code: _____

Telephone:_____Email: _____

_____ _____ _____

Full Name Signature Date

Exhibit 15

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO

CLAIMANT **AWARD OF COMPENSATION**

EMPLOYER

INSURER

Hearing was held in the above claim at Beltsville, Maryland on January 30, 2017; and as a result thereof, it is this 1st day of February, 2017, by the Workers' Compensation Commission ORDERED that the above-named employer and above-named insurer pay unto the above-named claimant compensation as follows:

1. TEMPORARY TOTAL DISABILITY: The claimant was paid temporary total disability from July 22, 2016 to August 5, 2016 inclusive; based on an average weekly wage of $400.00 for an occupational disease sustained on July 20, 2016.

2. PERMANENT PARTIAL DISABILITY: Resulting in 15% loss of use of the right hand, 8% loss of use of the left foot, and 8% loss of use of the right foot; at the rate of $267.00, payable weekly, beginning August 6, 2016, for a period of 77.5 weeks.

3. MEDICAL EXPENSES: The employer and insurer shall pay the medical expenses of St. Paul & Biddle and Pacific Rehab listed in the claimant's exhibits in accordance with the Medical Fee Guide of this Commission.

THIS AWARD IS SUBJECT TO A TOTAL ASSESSMENT OF SIX AND ONE-HALF PERCENT (6.5%) ON THE AWARD PURSUANT TO LABOR AND EMPLOYMENT ARTICLE, §9-806 (SUBSEQUENT INJURY FUND ASSESSMENT); ANNOTATED CODE OF MARYLAND. THE EMPLOYER OR INSURER SHALL PAY THE ASSESSMENT TO THE SUBSEQUENT INJURY FUND WITHIN THIRTY (30) DAYS FROM THE DATE OF INVOICE, IN ACCORDANCE WITH THE INSTRUCTIONS THEREON.

THIS AWARD IS SUBJECT TO A TOTAL ASSESSMENT OF TWO PERCENT (2%) ON THE AWARD PURSUANT TO LABOR AND EMPLOYMENT ARTICLE §9-1007(UNINSURED EMPLOYERS' FUND ASSESSMENT); ANNOTATED CODE OF MARYLAND. THE EMPLOYER OR INSURER SHALL PAY THE ASSESSMENT TO THE UNINSURED EMPLOYERS' FUND WITHIN THIRTY (30) DAYS FROM THE DATE OF INVOICE, IN ACCORDANCE WITH THE INSTRUCTIONS THEREON.

It is further ORDERED that from the final weeks of compensation the following fees shall be paid:

in the amount of $4,105.13 (plus $63.77/costs advanced)
in the amount of $500.00

ATTEST:
STACEY L. ROIG
SECRETARY

Commissioner

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO

CLAIMANT **ORDER**

EMPLOYER

INSURER

Hearing was held in the above claim at Beltsville, Maryland on February 25, 2015; and as a result thereof, it is this 4th day of March, 2015, by the Workers' Compensation Commission ORDERED that the above-named employer and above-named insurer shall pay for prior prescriptions written by Dr. and only shall authorize prescriptions at the next appointment with Dr in March, following which, no further medications shall be authorized.

Commissioner

la

ATTEST:
STACEY L. ROIG
SECRETARY

*** FILE COPY ***

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO
CLAIMANT
EMPLOYER
INSURER

SUPPLEMENTAL
AWARD OF COMPENSATION

STIPULATED

Hearing was held in the above claim at Beltsville, Maryland on February 25, 2015, on the following issues:

1. Additional temporary total disability
2. Payment of medical bills of .

The Commission finds that as a result of the accidental injury on September 15, 2014, the claimant was paid temporary total disability from September 16, 2014 to October 20, 2014 inclusive. The Commission finds on the issues presented that the claim for additional temporary total disability from October 21, 2014 to November 12, 2014 inclusive is allowed. The Commission finds that the employer/insurer shall pay the medical bills of . in accordance with the Medical Fee Guide of this Commission. Average weekly wage: $1,243.54.

It is, therefore, this 4th day of March, 2015, by the Workers' Compensation Commission ORDERED that compensation for temporary total disability terminate on October 20, 2014 inclusive; and further ORDERED that the above-named employer and above-named insurer pay unto the above-named claimant compensation for additional temporary total disability at the rate of $830.00, payable weekly, beginning October 21, 2014 to November 12, 2014 inclusive; and pay the medical bills of . in accordance with the Medical Fee Guide of this Commission. It is further ORDERED that the claim be held subject to further consideration by this Commission as to permanent partial disability, if any, the case will be reset only on request.

Commissioner

kb

ATTEST:
STACEY L. ROIG
SECRETARY

*** FILE COPY ***

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO
CLAIMANT **ORDER**
EMPLOYER
INSURER

Hearing was held in the above claim at Frederick, Maryland on February 25, 2015 on the following issues:

1. Work hardening for up to 8 weeks as recommended by , MPT in her functional capacity evaluation report dated 1/18/15
2. Vocational rehabilitation

The Commission finds that as a result of the accidental injury on August 4, 2014, the claimant was paid temporary total disability from August 5, 2014 to January 8, 2015 inclusive. The Commission finds on the first issue presented that work hardening for up to eight (8) weeks as recommended by , MPT in her functional capacity evaluation report dated January 8, 2015 is approved. The Commission will reserve on the second issue presented pending the results of work hardening. Average weekly wage $880.81.

It is, therefore, this 9th day of March, 2015 by the Workers' Compensation Commission ORDERED that the above named employer/insurer authorize work hardening for up to eight (8) weeks as recommended by , MPT in her functional capacity evaluation report dated January 8, 2015. It is further ORDERED that the above case be held subject to further consideration as to vocational rehabilitation pending results of work hardening and be reset only on request.

Commissioner

kb

ATTEST:
STACEY L. ROIG
SECRETARY

*** FILE COPY ***

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO
CLAIMANT **ORDER**
EMPLOYER
INSURER

Hearing was held in the above claim at Frederick, Maryland on February 5, 2015 on the following issues:

1. Temporary total disability.
2. Authorization for medical treatment.

The Commission finds that as a result of the accidental injury sustained on June 24, 2013, claimant was paid compensation for temporary total disability from June 25, 2013 to December 18, 2013, inclusive. The Commission finds on the first issue presented that claimant was again temporarily totally disabled from September 17, 2014 to December 11, 2014, inclusive. The Commission finds on the second issue presented that the request for physical therapy is denied. The Commission further finds that injections recommended by Dr. are authorized. Average weekly wage: $650.00.

It is, therefore, this 6th day of March, 2015, by the Workers' Compensation Commission ORDERED that the above-named employer and above-named insurer pay unto the above-named claimant compensation for temporary total disability at the rate of $434.00, payable weekly, beginning September 17, 2014 and ending December 11, 2014, inclusive; and further ORDERED that the injections recommended by Dr. are approved.

It is further ORDERED that from the compensation herein awarded, ttorney for claimant, is authorized a lump sum counsel fee in the amount of $529.48.

Chairman

al

ATTEST:
STACEY L. ROIG
SECRETARY

*** FILE COPY ***

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO
CLAIMANT ORDER
EMPLOYER
INSURER

Under date of July 11, 2014, an Agreement of Final Compromise and Settlement was filed with this Commission in the above-entitled claim; and it is, therefore, this 17th day of July, 2014, by the Workers' Compensation Commission ORDERED that the Agreement is hereby APPROVED as submitted.

THIS AWARD IS SUBJECT TO A TOTAL ASSESSMENT OF SIX AND ONE-HALF PERCENT (6.5%) ON THE AMOUNT PAYABLE PURSUANT TO LABOR AND EMPLOYMENT ARTICLE, §9-806 (SUBSEQUENT INJURY FUND ASSESSMENT); ANNOTATED CODE OF MARYLAND. THE EMPLOYER OR INSURER SHALL PAY THE ASSESSMENT TO THE SUBSEQUENT INJURY FUND WITHIN THIRTY (30) DAYS FROM THE DATE OF INVOICE, IN ACCORDANCE WITH THE INSTRUCTIONS THEREON.

THIS AWARD IS SUBJECT TO AN ADDITIONAL ASSESSMENT IN THE AMOUNT OF TWO PERCENT (2%) ON THE AMOUNT PAYABLE PURSUANT TO LABOR AND EMPLOYMENT ARTICLE §9-1007(B)(UNINSURED EMPLOYERS FUND ASSESSMENT); ANNOTATED CODE OF MARYLAND. THE EMPLOYER OR INSURER SHALL PAY THE ASSESSMENT TO THE UNINSURED EMPLOYERS FUND WITHIN THIRTY (30) DAYS FROM THE DATE OF INVOICE, IN ACCORDANCE WITH THE INSTRUCTIONS THEREON.

Commissioner

cc

ATTEST:
STACEY L. ROIG
SECRETARY

*** FILE COPY ***

Exhibit 16

WORKERS' COMPENSATION COMMISSION

INSURER'S TERMINATION OF TEMPORARY TOTAL DISABILITY BENEFITS

Pursuant to LE §9-733(b), Annotated Code of Maryland, this form must be sent to the claimant. A copy must also be sent to the Workers' Compensation Commission and claimant's attorney.

WCC Claim Number _____

Claimant _____

Employer _____

Insurer _____

This is your last temporary total disability compensation check/payment and includes benefits through: _____ **(date).**

The insurer/employer has terminated your payments for the following reason(s):

- ☐ **1.** You returned to work on _____. **(date)**
- ☐ 2. There is no medical evidence or documentation to support continuing payment.
- ☐ **3.** You failed to keep the medical appointment scheduled for _____. **(date)**
- ☐ 4. You have reached maximum medical improvement.
- ☐ 5. _____

For further information contact:

_____ **at** _____

Insurer Representative **Telephone Number**

After contacting the insurance representative, if you are in disagreement or are dissatisfied, you have the right to request a hearing before the Workers' Compensation Commission. Please include a copy of this form with your request for a hearing on the MD WCC "Issues" form (H24R) selecting the appropriate Temporary Total Disability issue (#13 or #17).

INSURER CERTIFICATION OF SERVICE

I hereby certify that on the _____ **day of** November, 2014, **I mailed, postage prepaid, a copy of the foregoing "INSURER'S TERMINATION OF TEMPORARY TOTAL DISABILITY BENEFITS" and any attached documentation to all parties and their attorneys.**

Signature _____

Name _____ Date _____

Telephone Number _____

Exhibit 17

WORKERS' COMPENSATION COMMISSION

INSURER'S TERMINATION OF MEDICAL BENEFITS

Pursuant to COMAR 14.09.06.04C, this form must be sent to the claimant. A copy must also be sent to the claimant's treating physician or health care provider, the Workers' Compensation Commission and the claimant's attorney.

WCC Claim Number: _____

Claimant: _____

Employer: _____

Insurer: _____

This is to advise that the insurer/employer will terminate payment for medical benefits under the above captioned claim effective: _____.

The claimant has the right to request a hearing before the Workers' Compensation Commission on the issue of this termination of medical benefits.

Health Care Provider: _____

Service or treatment being terminated:

Health Care Provider: _____

Service or treatment being terminated:

For further information, contact: _____ _____
Telephone Number

INSURER CERTIFICATION OF SERVICE

I hereby certify that on the ____ day of _____, 20__, a copy of this notice was sent to the Claimant, his/her counsel, the Maryland Workers' Compensation Commission and to the above named Health Care Provider(s).

Signature: _____ Date: _____

Printed Name: _____

Telephone Number: _____

Click Here to Clear the Form

Exhibit 18

WORKERS' COMPENSATION COMMISSION

AGREEMENT ON THE PROPRIETY OF SERVICES AND SELECTION OF PRACTITIONER

INSTRUCTIONS: This form must be submitted to the Workers' Compensation Commission and a copy sent to the selected vocational rehabilitation practitioner.

WCC CLAIM NUMBER: _____

CLAIMANT: _____

EMPLOYER: _____

INSURER: _____

Agreed Upon Vocational Rehabilitation Practitioner:

Practitioner Name: _____ WCC Number: _____

Address: _____

The undersigned hereby agrees to the propriety of vocational rehabilitation services and the selection of the above-named vocational rehabilitation practitioner.

Employer/Insurer Name	Signature
Telephone Number	Date
Claimant/Attorney Name	Signature
Telephone Number	Date

NOTICE

The practitioner may not contact the above claimant or initiate vocational rehabilitation services until the practitioner has received a copy of this notice.

CERTIFICATION OF SERVICE

I hereby certify that on this _____ day of _____, 20____, I mailed, postage prepaid, a copy of this AGREEMENT and any attached documentation to all parties and their attorneys.

Signature	Telephone

Exhibit 19

WORKERS' COMPENSATION COMMISSION
PROPOSED VOCATIONAL REHABILITATION PLAN

INSTRUCTIONS: Pursuant to COMAR 14.09.07.11B (3) , a vocational rehabilitation practitioner shall complete this form as soon as practicable after being notified of their selection under COMAR 14.09.07.09 and serve it on all the parties in the case.

CLAIM INFORMATION

WCC Claim #	Date of Injury	DOB	Insurance Company Name	Insurer File #
TT Benefits	SSI/SSDI Benefits	Other Benefits	Insurer's Attorney	Phone number
Claimant's Name:		Phone number	Insurer Rep/Adjuster	Phone Number
Address:			Employer Name/Location	
City	State	Zip Code	VR Counselor's Name	WCC Reg#
Claimant's Attorney		Phone number	VR Counselor's Business Address	
Educational level attained		Pre-injury Wage	Company/DORS Information	Work Phone Number
Pre-injury occupation		Anticipated Wages	Optional: VR counselor's email address	

SECTION I – VOCATIONAL REHABILITATION PLAN INFORMATION

Type of Plan Submission

**Please note that only Section I of the plan is required when extending the duration of VR services

☐ Informational

☐ Passed stated completion date

☐ Plan not signed by: _____

☐ All parties did not agree to the plan (briefly comment)

☐ Extension of Services (An order will not be issued/for filing only)

Date of original Plan submitted to the Commission: _____

Length of the proposed extension: _____

Comments:

SECTION II – PLAN SPECIFICATIONS

Services Proposed Confirm services recommended: (if Self-Employment then skip to D)	JOB PLACEMENT ☐	OJT ☐	RETRAINING ☐	SELF-EMPLOYMENT ☐

A. Duration of Plan: From:_____ To:_____ Plan Cost:_____

B. List Targeted Jobs:

1._____ DOT #:_____

2._____ DOT #:_____

3. _____ DOT #:_____

4._____ DOT #:_____

5._____ DOT #: _____

C. Service Proposed: (continued)

1) OJT/Training Facility Name:_____

OJT/Training Facility Street Address:_____

OJT/Training Facility City:_____ State:_____ Zip Code:_____

OJT/Training Facility Contact Person:_____

Phone #: _____

D. 1. Claimant's Diagnosis:

a) MMI: ◯ Yes ◯ No Date: _____

b) Released to Return to Work: ◯ Yes ◯ No

c) Give dates and summarize Physical Limitations/Functional Capacity Evaluation:

_____ _____

_____ _____

_____ _____

2. Treating Physician's Concurrence: ◯ Yes ◯ No (Less than six months/unless otherwise explain)
Explanation:

E. Confirm that the Hierarchy of Services has been explored (check the appropriate box)

☐ Return to work same job/same employer ☐ Return to modified job/same employer

☐ Return to work new job/same employer ☐ Return to work new job/different employer

☐ OJT Training ☐ Formal Retraining ☐ Self-Employment

Section III: Vocational Assessment/Rationale/Supporting Documentation

F. Vocational Assessment: How does the service proposed meet the definition of suitable gainful employment by addressing the qualifications, academics, interests, incentives, pre-disability earning, future earnings, physical appropriateness and labor market conditions?

G. Confirm that supporting documentation is attached:

- ☐ Vocational Assessment(must be included)
- ☐ Vocational test results
- ☐ Physical Limitations/FCE
- ☐ Wage Earnings Research/Analysis
- ☐ Local/Current Labor Market Analysis
- ☐ Plan Cost Outline/Estimates Medical
- ☐ Release to RTW

Section IV: Goals/Responsibilities

BRIEFLY STATE GOALS AND OBJECTIVES:

CLAIMANT'S RESPONSIBILITIES:

VR COUNSELOR'S RESPONSIBILITIES:

EMPLOYER/INSURER'S RESPONSIBILITIES:

C E R T I F I C A T I O N

I,_____, the undersigned disabled covered employee, do hereby certify that I have read the attached Vocational Rehabilitation Plan and that I understand the following:

1. This plan is an agreement that outlines each party's responsibilities with regard to my vocational rehabilitation.

2. The Insurer will pay rehabilitation benefits equal to weekly temporary total disability benefits as well as the expenses of the rehabilitation services.

3. The time frame(s) agreed to by the parties may be extended if necessary. If the Insurer refuses to agree to an extension and I believe I am entitled to additional rehabilitation services, I have the right to request a hearing before the Commission and to have a Commissioner determine whether services should be continued.

4. I am not required to accept any employment offered to me unless I agree that it is suitable employment. I am aware that if the Insurer believes the employment is suitable and I have declined to accept it, the Insurer may discontinue payment of rehabilitation benefits and expenses and assert my non-cooperation. I understand that I may request a hearing to have a Commissioner determine whether the employment offer was suitable employment.

5. The Insurer may stop benefit/expense payments if the Insurer determines that rehabilitation services are no longer necessary or if they determine that I am not cooperating in the rehabilitation effort.

6. If benefit/expense payments are stopped for any reason with which I do not agree, I have the right to request a hearing and have a Commissioner decide the issue.

7. I have a right to be an active participant in my rehabilitation and have both the right and the responsibility to express my desires and expectations.

8. I have a right to confer with an attorney regarding the terms of the rehabilitation plan.

I HAVE READ THIS CERTIFICATION AND/OR HAVE HAD IT EXPLAINED TO ME, AND I UNDERSTAND ITS PROVISIONS.

Printed Name_____Signature _____

WCC Claim No:_____ DATE:_____

Approval

Claimant must review and sign the certification (Page 4) prior to signing this Approval. The Certification must not be detached from the plan.

Claimant's acknowledgment: ◯ I have ◯ I have not reviewed and signed the Claimant's Certification.

This plan has been reviewed and approved by the undersigned parties:

Claimant:_____ Date: _____

Print or type full name here: _____

Claimant's Attorney:_____ Date: _____

Print or type full name here: _____

Insurer/Employer Representative:_____ Date: _____

Print or type full name here: _____

Insurer/Employer Attorney (if applicable):_____ Date: _____

Print or type full name here: _____

Rehabilitation Counselor:_____ Date: _____

Print or type full name here: _____

Training Representative:_____ Date: _____

Print or type full name here: _____

DORS Counselor (if applicable):_____ Date: _____

Print or type full name here: _____

Exhibit 20

WORKERS' COMPENSATION COMMISSION

DISAGREEMENT WITH PROPOSED VOCATIONAL REHABILITATION PLAN

INSTRUCTIONS: This form is to be used to notify the Commission of a party's disagreement with a proposed vocational rehabilitation plan. This form must be completed and returned to the Commission no later than 15 days from the date of the letter which transmitted the proposed plan to the parties.

CLAIM NUMBER:

CLAIMANT NAME:

EMPLOYER:

INSURER:

The undersigned

◯ Claimant/Claimant's Attorney ◯ Employer/Insurer's Attorney ◯ SIF/UEF ◯ Other _____

a party to this Workers' Compensation Claim, having reviewed the proposed vocational rehabilitation plan, disagrees with the plan for the following reasons:

BY:

FULL NAME: _____

ADDRESS: _____

SIGNATURE: _____ DATE OF REQUEST: _____

CERTIFICATION OF SERVICE

I hereby certify that on this ____ day of _____, 2____, I mailed, postage prepaid, a copy of this Disagreement with Proposed Vocational Rehabilitation Plan to all parties and their attorneys.

Signature	Date	Telephone

Exhibit 21

WORKERS' COMPENSATION COMMISSION

STIPULATION OF PARTIES AND AWARD OF COMPENSATION

WCC Claim Number: _____

Claimant: _____

Employer: _____

Insurer: _____

It is STIPULATED this ____ day of _____, _____ by and between the above-named parties, that an Award of Compensation is necessary and appropriate in the above-titled claim on the following information:

(1) Date of Accident: _____ Amended: Y N

(2) Claimant's Average Weekly Wage: $ _____ Amended: Y N

(3) Temporary Total / Temporary Partial:

(4) Attached hereto are the medical evaluation report(s) of:

Claimant's Doctor #1 _____ #2 _____

Insurer's Doctor #1 _____ #2 _____

(5) The Parties agree to a permanent partial disability of :

at the rate of $ _____, payable weekly, beginning _____ for _____ weeks.

IN WITNESS WHEREOF, the undersigned Parties have agreed to the aforementioned stipulation on the day and year as stated above.

ATTEST:

_____ _____

Signature of Attorney for Claimant Signature of Claimant

BY: _____

Signature for Employer/Insurer

The Claimant being unrepresented by Counsel, the Insurer furnishes herewith copies of all medical reports in its possession.

I, the undersigned, as Claimant in the above-entitled case, not being represented by Counsel, do hereby state that I understand that this Stipulation does not foreclose my future right to reopen my case or the right to continuing medical care; that I have the right to have any future claim heard before the MD Workers' Compensation Commission; that I would have a right to appeal any decision in the future to be made by the Workers' Compensation Commission; and that I have entered into this Stipulation only for the purpose of determining the degree of my disability at this time.

WITNESS:_____ CLAIMANT: _____
Signature Signature

---

(6) FEES AND COSTS

In accordance with COMAR 14.09.04.02, WCC Form H44, "Claimant's Consent to Pay Fees and Costs", MUST be submitted to the Workers' Compensation Commission.

CONSENT OF CLAIMANT: The Claimant in this case has read and signed the Stipulation and consents to the fees as set forth in the attached WCC Form H-44.

_____
Signature of Claimant

Exhibit 22

WORKERS' COMPENSATION COMMISSION
STATE OF MARYLAND

	*	
Claimant	*	
v.	*	**WCC No.:**
	*	
Employer	*	
and	*	
	*	
Insurer	*	

* * * * * * * * * * * *

AGREEMENT OF FINAL COMPROMISE AND SETTLEMENT

THIS AGREEMENT made this _____ day of _____, 2017 by and between , (hereinafter "the Claimant"), and , (hereinafter "the Employer"), and , (hereinafter "the Insurer") WITNESSETH:

WHEREAS, the Claimant has filed a claim with the Workers' Compensation Commission of Maryland (hereinafter the "Commission"), to recover workers' compensation benefits for alleged disability resulting from an accidental personal injury arising out of and in the course of his employment with the Employer, which injury is alleged to have occurred on or about October 24, 2016; and

WHEREAS, the Claimant was earning an average weekly wage of $891.07 at the time of the alleged injury. Claimant was born on and is currently 31 years and 11 months of age. Temporary total disability benefits were paid to the Claimant from November 23, 2016 through February 8, 2017. The total amount of indemnity paid to the Claimant is $11,711.27; and

WHEREAS, the Employer and Insurer deny the allegations of the Claimant, either in whole or in part, so that there now exists a dispute between the Claimant on the one hand, and the Employer and Insurer on the other, as to whether the Claimant is entitled to any workers' compensation benefits and/or, if so entitled, as to the nature and extent of disability involved and the benefits or additional benefits to be paid or provided; and

WHEREAS, irrespective of and notwithstanding the divergent views held by the parties hereto concerning the occurrence of the aforesaid personal injury, the nature and extent of the disability resulting therefrom, the workers' compensation benefits allowable therefor, and all other benefits or rights that any of the parties hereto might or could have in the premises, the parties have reached an agreement providing, subject to the approval of the Commission, for a final compromise and settlement of any and all claims which the Claimant or his personal representative or beneficiaries might now or could hereafter have under the provisions of the said Workers' Compensation law against the Employer and/or the Insurer and any and all claims which the Employer and Insurer or successors might now or could hereafter have under the provisions of said Workers' Compensation Law and any other applicable laws against the Claimant, his personal representative, or beneficiaries or any other person or entity known or unknown;

NOW THEREFORE, it is hereby agreed as follows:

1. **The Employer and Insurer hereby agree to pay the Claimant the sum of SIXTEEN THOUSAND DOLLARS ($16,000.00) (LUMP-SUM) IN EXCHANGE FOR A FULL AND FINAL SETTLEMENT OF THIS CLAIM.**

2. The Claimant shall remain entitled to receive all reasonable, necessary and causally related medical treatment, at the expense of the Employer and Insurer up to the date of approval of this Agreement.

3. The parties certify that this agreement satisfies all the conditions under 42 CFR 411.46 (Medicare Regulation).

4. The Claimant hereby accepts the said agreement and the aforesaid payment(s) in final compromise and settlement of any and all claims which the Claimant, or his personal representative, dependents, spouse and children or any other parties who might become beneficiaries under the said Workers' Compensation Laws might now or could hereafter have under the provisions of the said law, arising out of the aforesaid injury or disablement or the disability resulting therefrom, and does hereby, on behalf of himself and all of said other parties, release and forever discharge the employer and insurer, their personal representative, heirs, successors and assigns, from all other claims of whatsoever kind which might or could hereafter arise under the said Law from the said injury, disablement or disability.

5. The parties have considered the interests of Medicare and determined that the Claimant will not require further medical treatment as it relates to this claim based on the medical opinion of , M.D. dated October 12, 2017 that the Claimant is at maximum medical improvement and does not require additional treatment in relation to the October 24, 2016 injury. A copy of Dr. October 12, 2017 report is attached hereto and incorporated herein as Exhibit 1. As a result, there is no allocation for future medical treatment associated with the instant claim, and for which no future treatment is recommended or expected at this time.

6. The parties hereby acknowledge and have considered the potential impact of the

Medicare Secondary Payer statute, 42 U.S.C. §1395(b), on lump sum settlements that purport to release employers/carriers from liability for future medical expenses. The parties further acknowledge that if Medicare's interest in the lump sum payment is not adequately considered per 42 C.F.R. §411.46, Medicare may refuse to make medical payments if the Claimant is entitled to Medicare benefits. Furthermore, the parties acknowledge if Medicare makes conditional payments of medical expenses that the Center for Medical and Medicaid Services ("CMS") determines should have been paid by the primary payer, CMS has the authority to seek reimbursement for those conditional payments, as well as interest, from virtually any entity involved in the claim. Finally, CMS may continue to hold employers/carriers responsible for future Medicare payments if medical expenses are compromised without approval of the settlement by CMS. The Insurer will reimburse Medicare for any provisional or conditional payments made by Medicare that are ultimately determined to be the responsibility of the Employer and Insurer.

7. In consideration of the above, Claimant hereby agrees and acknowledges that he is not eligible for Medicare and that Medicare has not paid for any of his treatment related to the injury. The Claimant also acknowledges and understands that should he receive any further treatment related to the work injury, he cannot seek to transfer the costs of such treatment onto Medicare.

8. The parties hereby acknowledge that should Medicare pay for any treatment related to these injuries, the consequences could include Medicare doing one or more of the following: (a) imposing sanctions on all parties, (b) denying medical treatment, (c) designating its own allocation of proceeds for medical treatment (which may be the total amount of the settlement), and (d) then suing all parties of this agreement for repayment of that medical amount.

9. Whereas, Claimant may be entitled in the future to receive Social Security Disability Insurance Benefits For computation and proration purposes of any Social Security offset, the following should be noted; (1) The Claimant is disabled for life, and this Agreement represents the only workers' compensation benefits he will ever receive in the future for this claim; (2) Therefore, proration of any claimed offset should be based upon the Claimant's life expectancy; (3) That the Claimant is thirty-one (31) years old; (4) That according to Vital Statistics of the United States Life Tables, Table 5, 2013 Edition, a copy of which is attached hereto and made a part hereof, the Claimant is a white male, thirty-one (31) years old, he has a life expectancy of 47.2 years or 566 months; (5) That after deduction of excludable legal expenses in the total amount of $6,968.07, from the total settlement of $16,000.00, the Claimant will be left with net settlement proceeds representing permanent disability benefits of $9,031.93, which if paid out over his remaining life expectancy of 566 months, would be equivalent to $15.95 per month, to be set off of any future Social Security Disability benefits.

10. This Agreement is made subject to the approval of the Commission, and when so approved shall immediately become effective and binding upon all of the parties hereto.

Claimant

Attorney for Claimant

Attorney for Employer/Insurer

APPROVAL AND ORDER

The Workers' Compensation Commission of Maryland hereby signifies this _____ of_____, 2017 its approval of the foregoing Agreement of Final Compromise and Settlement and directs the Employer and Insurer to pay the sum of SIXTEEN THOUSAND DOLLARS ($16,000.00) (LUMP-SUM) in full and final settlement of their rights and obligations as set forth in said Agreement, as follows:

To:	Attorney's Fee	$(
To:	Reimbursement of expenses:	$
To:	Medical Fees:	$(
		$(
To:	Payable in a lump-sum at the time of approval.	$(
	TOTAL	$16,000.00

_____

Commissioner

WORKERS' COMPENSATION COMMISSION

CLAIMANT'S AFFIDAVIT IN SUPPORT OF SETTLEMENT

I,_____, am the claimant in claim #_____.

I ask the Workers' Compensation Commission to approve the settlement of my claim and in support of this request state:

1. I am over eighteen (18) years of age and am competent to testify.
2. I am voluntarily settling my claim.
3. I acknowledge that in settling my claim, I am giving up the following rights:
    a. the right to hearings before the Workers' Compensation Commission for resolution of any disputes regarding my claim;
    b. the right to vocational rehabilitation services and to payment during my lifetime for any medical treatment related to my claim, except as provided, if at all, in this settlement;
    c. the right, except as provided, if at all, in this settlement, to be compensated, under certain conditions, by the Subsequent Injury Fund for permanent impairments incurred before the accidental injury or occupational disease which gave rise to my claim;
    d. the right to ask the Workers' Compensation Commission, within 5 years of the last payment of any compensation that it might have ordered, to reopen my claim should my condition related to my claim worsen;
    e. the right to appeal to the appropriate Circuit Court if I am dissatisfied with a decision of the Workers' Compensation Commission;
    f. the right to appeal to the Court of Special Appeals if I am dissatisfied with the decision of the Circuit Court; and
    g. the right to petition the Court of Appeals to review the decision of the Court of Special Appeals if I am dissatisfied with the decision of the Court of Special Appeals; and
4. that, by signing this affidavit, I acknowledge that I have read, and understand, the terms of this settlement and all the documents attached in support of it, including medical reports and this affidavit.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing affidavit are true and accurate.

I, as attorney for the claimant, have reviewed this affidavit with the claimant.

_____
Claimant's Signature

_____
Claimant's Name (printed)

_____
Date

_____
Attorney for Claimant Signature

_____
Attorney for Claimant Name (printed)

_____
Date

10 East Baltimore Street w Baltimore, Maryland 21202-1641
410-864-5100 w Email: info@wcc.state.md.us w Web: http://www.wcc.state.md.us

WORKERS' COMPENSATION COMMISSION

SETTLEMENT WORKSHEET

Claimant: _____ Claim No.: _____

Claimant Atty.: _____ Atty. Telephone: _____

Claimant's age: _____ years, _____ months

Employer: _____

Insurer: _____

E/I Atty. or Rep.:

All questions must be answered. Any incomplete or missing information will cause the Settlement Worksheet to be returned and approval of the settlement delayed.

1. Has this settlement been previously submitted and previously denied? ☐ Yes ☐ No
2. Is the claim contested as to compensability and/or causation? ☐ Yes ☐ No
3. Are further medical treatments recommended for the injury? ☐ Yes ☐ No
4. Is there any potential SIF liability in the case? ☐ Yes ☐ No
5. Is the Claimant working? ☐ Yes ☐ No
6. Does this case involve a third party claim? ☐ Yes ☐ No
   If yes, attach document required by COMAR 14.09.10.02C.
7. Is the claim on appeal? ☐ Yes ☐ No
8. Is a hearing on the claim pending? ☐ Yes ☐ No
   If yes, when? _____
9. Has Claimant applied for Social Security Disability benefits? ☐ Yes ☐ No
   If yes, when (date)?
10. Is SSDI claim pending or on appeal? ☐ Yes ☐ No
11. Date SSDI approved: _____ or ☐ N/A
12. Has Claimant applied for Medicare benefits? ☐ Yes ☐ No
    If yes, when (date)?
13. Is Medicare claim pending or on appeal? ☐ Yes ☐ No
14. Date Medicare approved: _____ **OR** ☐ N/A

SETTLEMENT WORKSHEET

15. Does Claimant have End State Renal Disease (ESRD)? ☐ Yes ☐ No

16. Amount of Total Proposed Settlement: _____

17. Total Amount of Indemnity paid to Claimant to date: _____

18. Has a professional evaluator identified probable future Medicare covered expenses? ☐ Yes ☐ No
    If yes, attach professional evaluation.

19. Has proposed Medicare Set Aside been submitted to CMS? ☐ Yes ☐ No
    If yes, date submitted: _____

20. Is CMS approval of the MSA pending? ☐ Yes ☐ No

21. Date CMS approved MSA: _____ **OR** ☐ N/A

22. Is there a formal medical set aside allocation? ☐ Yes ☐ No
    If yes, state amount:
    If yes, is the MSA administered by a TPA or paid as an annuity, with no current or future reversionary interest to claimant? ☐ Yes ☐ No

23. Has some of the settlement been apportioned to future medicals? ☐ Yes ☐ No
    If yes, attach medical evaluation or opinion.

24. Date of disablement by accidental injury or occupational disease: _____

25. Are medicals being left open? ☐ Yes ☐ No

26. Comments:

I hereby certify that the foregoing is true and accurate based on my personal knowledge, information and belief.

Claimant Signature **(Date)** **Attorney Signature** **(Date)**

WORKERS' COMPENSATION COMMISSION
10 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

CLAIM NO	B767182	
CLAIMANT	ALVIN P BEASLEY	**ORDER**
EMPLOYER	PENSKE TRUCK LEASING CO LP	
INSURER	OLD REPUBLIC INSURANCE CO.	

Under date of February 18, 2015, an Agreement of Final Compromise and Settlement was filed with this Commission in the above-entitled claim; and it is, therefore, this 25th day of February, 2015, by the Workers' Compensation Commission ORDERED that the Agreement is hereby APPROVED WITH THE FOLLOWING MODIFICATIONS:

Dr. Kenneth Lippman, MD in the amount of $605.58

THIS AWARD IS SUBJECT TO A TOTAL ASSESSMENT OF SIX AND ONE-HALF PERCENT (6.5%) ON THE AMOUNT PAYABLE PURSUANT TO LABOR AND EMPLOYMENT ARTICLE, §9-806 (SUBSEQUENT INJURY FUND ASSESSMENT); ANNOTATED CODE OF MARYLAND. THE EMPLOYER OR INSURER SHALL PAY THE ASSESSMENT TO THE SUBSEQUENT INJURY FUND WITHIN THIRTY (30) DAYS FROM THE DATE OF INVOICE, IN ACCORDANCE WITH THE INSTRUCTIONS THEREON.

THIS AWARD IS SUBJECT TO AN ADDITIONAL ASSESSMENT IN THE AMOUNT OF TWO PERCENT (2%) ON THE AMOUNT PAYABLE PURSUANT TO LABOR AND EMPLOYMENT ARTICLE §9-1007(B)(UNINSURED EMPLOYERS FUND ASSESSMENT); ANNOTATED CODE OF MARYLAND. THE EMPLOYER OR INSURER SHALL PAY THE ASSESSMENT TO THE UNINSURED EMPLOYERS FUND WITHIN THIRTY (30) DAYS FROM THE DATE OF INVOICE, IN ACCORDANCE WITH THE INSTRUCTIONS THEREON.

Maureen Quinn
Commissioner

mh

ATTEST:
STACEY L. ROIG
SECRETARY

*** FILE COPY ***

Exhibit 23

REQUEST FOR EMPLOYER DESIGNEE TO RECEIVE NOTICE OF EMPLOYEE CLAIMS

This form is to be used only for employers to designate a person to receive a copy of each Notice of Employee's Claim (C-30) pursuant to Regulation 14.09.01.23(c)(2). *Please note that this request will apply to all locations with the identical Employer name, regardless of the address. For special circumstances, please contact the Claims Division.*

Name of Employer: _____

Address: _____

_____ _____ _____

Telephone Number: _____

The above-named employer, pursuant to Regulation 14.09.01.23(c)(2), requests that a copy of each Notice of Employee's Claim (C-30) filed against it be sent to:

Name of Designee: _____

Address: _____

_____ _____ _____

Telephone Number: _____

Requested By: _____
Employer

_____ _____
Authorized Signature **Date**

Title _____ **Telephone Number** _____

Address _____

_____ _____ _____

WCC Form H23R (06/15/09)

FRANKLIN & PROKOPIK
A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW

The B & O Building
2 N. Charles Street, Suite 600
Baltimore, Maryland 21201
410.752.8700
410.752.6868 Fax

111 North West Street
Suite 200
Easton, Maryland 21601
410.820.0600
410.820.0300 Fax

1101 Opal Court
Hub Plaza, Suite 210
Hagerstown, Maryland 21740
301.745.3900
301.766.4676 Fax

2325 Dulles Corner Boulevard
Suite 1150
Herndon, Virginia 20171
703.793.1800
703.793.0298 Fax

500 Creek View Road
Suite 502
Newark, Delaware 19711
302.594.9780
302.594.9785 Fax

5516 Falmouth Street
Suite 203
Richmond, Virginia 23230
804.932.1996
804.403.6007 Fax