A sample Claims Disposition Agreement follows. See also the Oregon Workers’ Compensation Board website (<https://www.oregon.gov/wcb/Pages/index.aspx>) for active bulletins and additional information on Claim Disposition Agreements and any related informational enclosures.

**BEFORE THE WORKERS' COMPENSATION BOARD**

# FOR THE STATE OF OREGON

IN THE MATTER OF THE COMPENSATION ) CDA No.:

 ) WCB No.:

 ) WCD No.:

 ) Claim No.:

 ) D.O.I.:

 OF ) Employer:

 ) Insurer:

 ) Administrator:

**WORKER’S NAME**, )

 ) **CLAIM DISPOSITION AGREEMENT**

 ) PURSUANT TO ORS 656.236

 Claimant. ) AND OAR 438-009-0022

**TYPE OF RELEASE**  **ISSUE/BENEFIT RELEASED**

**Full Partial**

 Temporary Disability

 Permanent Disability

 Vocational Assistance

 Survivor's Benefits

 All rights under the Workers’ Compensation Act, Chapter

656 of ORS, except medical services, penalties and attorney fees related to medical services, and for assistance from the Re-Employment Assistance Reserve to the extent that claimant may be entitled to pursuant to OAR 436-105-0001 et seq., and 436-110-0001 et seq., and insurer’s (self-insured employer) rights to recover its lien pursuant to ORS 656.593

**AMOUNT OF DISPOSITION**

$ Total Due Attorney (subject to WCB approval)

$ Total Due Claimant

**METHOD OF PAYMENT** (check one)

 **WAIVER OF "30-DAY" PERIOD**

 Lump Sum

 Structured Settlement YES NO

 Both of the Above

1. Claimant's name and address:

2. Employer's name and address:

3. Insurer’s/Administrator’s name and address:

4. Claimant’s attorney’s name and address:

5. Employer's/Insurer’s/Administrator’s attorney's name and address:

 .

6. The accepted condition(s) subject to this claim disposition agreement is/are .

7. This claim was first closed on \_\_\_\_\_\_\_\_\_\_\_\_\_ (date).

8. The total amount (percent) of permanent disability benefits awarded on the claim is \_\_\_\_\_\_\_\_\_\_\_\_ percent permanent partial disability.

9. The worker has/has not been able to return to the work force following the industrial injury or occupational disease.

10. The worker's age is \_\_\_\_ years and his/her highest educational level is . The extent of vocational training (or, if the worker is deceased, the age, highest education level, and the extent of vocational training of the worker’s beneficiaries) is/are:
 .

11. The following is a list of occupations that the worker has performed (or, if the worker is deceased, a list of occupations that each of the deceased worker’s beneficiaries has performed): .

12. Pursuant to ORS 656.236, in consideration of the payment of $\_\_\_\_\_\_\_\_\_\_\_ by the administrator/insurer/employer, claimant releases his/her right to the following workers’ compensation benefits for claimant’s life: temporary disability, permanent disability, vocational assistance and rehabilitation, authorized training programs, and reimbursements as those benefits may be related to the conditions accepted in this claim, penalties and attorney fees related to any of the issues being released, survivor's benefits, and any other benefits under the Workers' Compensation Act with the exception of medical services under ORS 656.245, ORS 656.273, and ORS 656.278 and penalties and attorneys fees for any post approval disputes. The employer's obligation to provide these benefits is also released.

The administrator’s/insurer's/employer's obligation to provide these benefits for claimant's life is also released. The parties expressly agree that any and all conditions accepted at any time in this claim are contemplated and encompassed by and subject to this Claim Disposition Agreement. The parties expressly agree that the administrator/insurer/employer preserves its rights to the following: third party rights under this claim, including the entitlement to recovery of its statutory third party lien pursuant to ORS 656.576 through ORS 656.596, if any; recovery and recoupment of benefits, offsets or overpaid compensation; its civil remedies, administrative remedies and/or any other remedies, including for recovery of benefits paid due to fraud or misrepresentation.

13. Out of the above consideration, an attorney fee of $\_\_\_\_\_\_\_\_\_\_ shall be paid as a reasonable attorney fee.

 a. The attorney fee does not exceed the Board’s rule (OAR 438-015-0052), and there are no extraordinary circumstances that justify an extraordinary fee.

 b. The agreement is not to be paid in installments, and there is no cost of an annuity. The present value of the agreement is as previously stated herein.

14. Claimant retains his/her right to medical service-related benefits for the compensable injury (including medical services allowed under ORS 656.245, ORS 656.273 and ORS 656.278, as well as penalties/attorney fees related to such medical service claims) and his/her eligibility for preferred worker status.

15. Claimant was given a written informational enclosure, separate from the agreement, in the form prescribed by the Board pursuant to OAR 438-009-0022. By their signatures below, claimant and claimant’s attorney verify that claimant has read the written informational enclosure and this Claim Disposition Agreement or that claimant has had them comprehensively read to claimant in their entirety and that claimant understands the contents of the written informational enclosure and this Claim Disposition Agreement.

**NOTICE TO CLAIMANT: UNLESS YOU ARE REPRESENTED BY AN ATTORNEY AND YOUR CLAIM DISPOSITION AGREEMENT INCLUDES A PROVISION WHICH WAIVES THE 30-DAY "COOLING OFF" PERIOD, YOU WILL RECEIVE A NOTICE FROM THE WORKERS' COMPENSATION BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT TELLING YOU THE DATE THIS AGREEMENT WAS RECEIVED BY THEM FOR APPROVAL. YOU HAVE 30 DAYS FROM THE DATE THE BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT RECEIVES THE AGREEMENT TO REJECT THE AGREEMENT, BY TELLING THE BOARD OR THE ADMINISTRATIVE LAW JUDGE WHO MEDIATED THE AGREEMENT IN WRITING. DURING THE 30 DAYS ALL OTHER PROCEEDINGS AND PAYMENT OBLIGATIONS OF THE INSURER/SELF-INSURED EMPLOYER, EXCEPT FOR MEDICAL SERVICES, ARE STAYED ON YOUR CLAIM. IF YOU DO NOT HAVE AN ATTORNEY, YOU MAY DISCUSS THIS AGREEMENT WITH THE BOARD IN PERSON WITHOUT FEE OR CHARGE. TO CONTACT THE BOARD, WRITE OR CALL: WORKERS' COMPENSATION BOARD, 2601 25TH STREET SE, SUITE 150, SALEM, OREGON 97302-1280, TELEPHONE: (503) 378-3308, TOLL-FREE AT 1-877-311-8061, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.**

**YOU MAY ALSO DISCUSS THIS AGREEMENT WITH THE OMBUDSMAN FOR INJURED WORKERS, WITHOUT FEE OR CHARGE. TO CONTACT THE OMBUDSMAN, WRITE OR CALL: OMBUDSMAN FOR INJURED WORKERS, LABOR & INDUSTRIES BUILDING, 350 WINTER STREET NE, SALEM, OR 97310, TELEPHONE: TOLL-FREE AT 1-800-927-1271, 8:00 TO 5:00, MONDAY THROUGH FRIDAY.**

**YOU MAY ALSO CALL THE WORKERS' COMPENSATION DIVISION'S INJURED WORKER HOTLINE, TOLL-FREE AT 1-800-452-0288.**

16. Payment of the disposition shall be made no later than the 14th day after notice of the Board’s approval or the administrative law judge who mediated the agreement’s approval has been mailed or distributed to the parties or their representatives under OAR 438-009-0030(5) and (6) by means of an order, posting on WCB’s website, electronic distribution through WCB’s website portal, or postcard. See OAR 438-009-0028; OAR 438-009-0030(7).

17. On Board approval of this agreement or on approval of the administrative law judge who mediated the agreement, the following requests for hearing/review shall be dismissed: WCB Case No.: .

18. Claimant acknowledges that he/she has reviewed the description of benefits, as described in this agreement and the informational enclosure prescribed in OAR 438-009-0022, and has had opportunity to ask questions of his/her attorney or the administrator/insurer/employer to further understand the consequences of signing this agreement.

19. Claimant is represented by an attorney and parties agree to waive the “30 day” waiting period under ORS 656.236(1)(b) for Board approval of this agreement.

**IT IS SO STIPULATED AND AGREED**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

[Typed Name], Claimant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

[Typed Name], Attorney for Claimant Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

[Typed Name], Attorney for Insurer/Employer/Administrator Date

**THIS AGREEMENT IS IN ACCORDANCE WITH THE TERMS AND CONDITIONS PRESCRIBED BY THE BOARD. SEE ORS 656.236(1). ACCORDINGLY, THIS CLAIM DISPOSITION AGREEMENT IS APPROVED. AN ATTORNEY FEE PAYABLE TO CLAIMANT'S ATTORNEY ACCORDING TO THE TERMS OF THIS AGREEMENT IS ALSO APPROVED.**

 **IT IS SO ORDERED.**

 DATED THIS DAY OF , 20\_\_.

 Board Member or Administrative Law Judge Who Mediated the Agreement

 Board Member

**NOTICE TO ALL PARTIES: THIS ORDER IS FINAL AND IS NOT SUBJECT TO REVIEW. ORS 656.236(2).**

**IMPORTANT NOTICES**

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