

Application for Approval of Lump-sum Payment of Award

Worker

Worker's name: _____ Phone: _____

Worker's address: _____

Date of injury: _____ Claim no.: _____

Worker's attorney: _____

Employer name: _____

Mailing date(s) of order (the form that described your PPD award): _____

Amount of PPD award: \$ _____

I request approval of a lump-sum payment of the remaining balance of my award.

OR

I request approval of a partial lump-sum payment of my award in the amount of \$ _____. I understand any remaining balance will be paid to me in monthly installments until full payment has been made.

I understand that by applying for and accepting a lump-sum payment of any part of my permanent disability award, I give up the right to appeal the amount of the award.

Worker signature

Date

If you have questions about this application or the insurer's objection to pay your award in a lump sum, contact the Ombudsman for Injured Workers (800) 927-1271 or the Workers' Compensation Division (800) 452-0288.

Worker . . . return this form to your insurer (see insurer address at top)

Insurer

Notice to the insurer: If you object to the payment of this award in a lump sum, check the reasons for the objection below, and return a copy to the worker within 14 days. (ORS 656.230)

The worker has not waived the right to appeal the adequacy of the award.

The award has not become final by operation of law.

The payment of compensation has been stayed pending a request for hearing or review.

The worker is enrolled and engaged in a vocational training program, will start the program within 30 days, or has temporarily withdrawn from a training program.

Authorized insurer representative signature

Date