

D. I am the person entitled to workers' compensation benefits on account of the indicated injury or death. I have read the foregoing and all attachments. Upon receipt of the indicated sums and approval by the workers' compensation commissioner, I release and discharge the named employer and insurance carrier from **all liability** under the Iowa Workers Compensation Law which is now in existence or may exist in the future on account of the indicated injury.

I consent to the degree of disability and the granting of the commutation. In the event the employer consents to the commutation, I waive any provision concerning contested cases as provided in Chapter 17A or otherwise.

If I am not represented, I waive my right to an attorney

Claimant's Attorney	Date	Claimant	Date
Email Address of Attorney		Fax Number of Attorney	

State of Iowa
 _____ } SS

On this _____ day of _____, _____ before me personally appeared the above claimant to me known to be the identical person named in and who executed the foregoing instrument and acknowledged that the document has been read and executed as a voluntary act.

 Notary Public

E. EMPLOYER

1. The employer/insurance carrier consents to the degree of disability and the granting of the commutation and waives any provision concerning contested cases as provided in Chapter 17A or otherwise.

Employer/Insurance Carrier	Date
Email Address	
Fax Number	

2. The employer/insurance carrier resists the relief sought in the petition for commutation but acknowledges delivery of a copy of the original notice and petition.

(Check one) A hearing is waived A hearing is requested

Employer/Insurance Carrier	Date
Email Address	
Fax Number	


The foregoing Application for Commutation is approved and the relief sought is granted _____, _____.

 Iowa Workers' Compensation Commissioner

NOTICE TO APPLICANT

DELIVERY OF FORM

1. Delivery of this form is to be by personal service as in civil actions or by certified mail, return receipt requested. Rule 876 IAC 4.7.
2. A copy of this form with proof of delivery and claimant's confidential information sheet, must be filed with the Division of Workers' Compensation no later than 10 days after delivery upon the respondent. Rule 876 IAC 4.8.
3. The Commissioner will not deliver this form to the respondent for a petitioner.



DIVISION OF WORKERS' COMPENSATION, 1000 EAST GRAND AVENUE, DES MOINES, IOWA 50319-0209 (515) 281-5387