

**AGREEMENT BETWEEN PARTIES
FOR LUMP SUM PAYMENT**

State Form 34873 (R / 10-87)

INDIANA WORKER'S COMPENSATION BOARD
Room 601 State Office Building
100 North Senate Avenue
Indianapolis, IN 46204

(See reverse side for fatalities)

Privacy Notice: This agency is requesting disclosure of employee's Social Security Number in accordance with I.C. 22-3-4-13.

Federal Identification Number	Employee Name
Social Security Number	Employee Name

AGREEMENT

The above name employer and the employee agree that _____ weeks of the remainder of weekly commission liability may be redeemed by a cash payment of a lump sum. The employee received \$ _____ in benefits for _____ weeks of temporary total disability. An agreement has been reached regarding permanent partial impairment for _____. The employer has made weekly payments in the amount of \$ _____ for _____ weeks for this impairment. It is in the best interest of the employee that he / she receive a lump sum payment for the following reasons, viz: _____

Wherefore, the employer and the employee respectfully request the Board to approve the agreement for a lump sum by which _____ weeks of said compensation liability may be redeemed by a single cash payment of _____.

Signature of Employee	Date Signed	(For Board Use)
Signature of Employer	Date Signed	
Signature of Insurance Company Representative	Date Signed	
Name, address and telephone number of insurance company:		
For Board Use Only		