Insurer name, address, and phone:

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's 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.

Waiver

☐ I waive my right to request reconsideration of the Notice of Closure mailed on _____ , by signing this application.

IMPORTANT: If you ask for a lump-sum payment of an award that is more than $6,000 and waive your right to request reconsideration, you give up the right to appeal the Notice of Closure, including 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 Ombuds Office for Oregon Workers at 800-927-1271 or the Workers' Compensation Division at 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 and OAR 436-060-0060).

☐ The worker has not waived the right to request reconsideration of the notice of closure. (ORS 656.230 and OAR 436-060-0060)

☐ We have timely requested reconsideration of the notice of closure under ORS 656.268(5)(e), and the reconsideration proceeding has not yet been completed.

☐ The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313.

☐ 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is enrolled and engaged in a vocational training program, will start the program within 30 days, or has temporarily withdrawn from a training program. (ORS 656.230 and OAR 436-060-0060)

_____ _____

Authorized insurer representative signature *Date*