EMPLOYMENT STANDARDS DIVISION
SETTLEMENT/ADVANCE RECAP SHEET

Please complete the applicable sections

PETITION TITLE:

1.
CLAIMANT: ACN# Claim#:

D/A or OD:
(Include all Dates)
INSURER PRIMARY CLAIM (S) #:

ADDITIONAL CLAIMS

DATES OF INJURY PRE 7/1/87

2.

Pre Lump Sum:	**Post Lump Sum:**
Income: $	**Income: $**
Expenses: $	**Expenses: $**
Differences: $	**Differences: $**

For dates of injury prior to April 15, 1985: See Instructions

For dates of injury between April 15, 1985 and June 30, 1987: See Instructions

3. **DATES OF INJURY POST 7/1/91**

703 Benefits:

PPD Rate: $

Age:	%	Education:	%	Wage Loss:	%
Restrictions:	%	Impairment:	%	Total Award:	%

Claimant's wage at the time of injury: $
Has the claimant been released to job of injury? Yes ☐ No ☐
Is the claimant currently working? (**If yes, current wage**) Yes ☐ No ☐
Current Wage: $

For Permanent Total Disability Settlements/Advances: See Instructions

4. **SETTLEMENT/LUMP SUM ADVANCE INFORMATION (ALL DATES OF INJURY)**

Impairment Rating date or MMI date (**All settlements require MMI date or date released to return to work**):

Impairment Rating % Paid: Yes ☐ No ☐

Settlement/Advance Amount: $

Settlement/Advance Rationale & Calculations (**include present value calculations if applicable**):

5.
Claimant's Signature: _____ Insurer's Signature: _____
(or authorized representative) (or authorized representative)
TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE AND CORRECT

6. Claimant's Attorney: Fee: $
(Do not include costs)

7.
Reviewed by: Date:
(ESD Examiner)

Questions concerning this form should be addressed to: Employment Standards Division
Workers' Compensation Compliance Bureau
PO Box 8011
Helena MT 59604-8011 Phone (406) 444-6543