FORM CS-APPENDIX

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

COMPROMISE SETTLEMENT APPENDIX

In re Claim of: (Please type or Print ALL information legibly in ink.)

Full Name of ☐ Injured Employee ☐ Deceased Employee if a Death Claim
Social Security Number (LAST 4 DIGITS ONLY) of: ☐ Injured Employee ☐ Deceased Employee if a Death Claim XXX– XX-_____
Name of Employer
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

WCC File Number
☐ Date of Injury ☐ Date of Death if a Death Claim

Use and attach to a Form CS-339(A) or a Form CSD-337 (Death Claim), as applicable, ONLY IF the Compromise Settlement seeks to settle and determine SOME, BUT NOT ALL, issues and matters in the claim. Identify the outstanding issues that are subject to the Court's continuing jurisdiction. *NOTE: The original and five (5) copies of the Compromise Settlement with Appendix attached are required when the settlement order is submitted to the Court of Existing Claims for filing.*

By signing below, each party affirms that they have read and understand the provisions of this COMPROMISE SETTLEMENT APPENDIX, declares under penalty of perjury that all statements are true and accurate to the best of their knowledge and belief, and understands that the Compromise Settlement Appendix, if approved by the Court of Existing Claims, is conclusive, final and binding on all parties involved. ***Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.***

_____
Name of Claimant

X_____
Signature of Claimant DATE

_____
Address of Claimant

_____
Type or Print Name of Claimant's Attorney, if any OBA#

X_____
Signature of Claimant's Attorney, if any DATE

_____
Name of Respondent

_____
Name of Insurance Carrier or Own Risk Group

_____
Type or Print Name of Respondent/Insurer Attorney OBA#

X_____
Signature of Respondent/Insurer Attorney DATE