

CLINCHER AGREEMENT INFORMATION

Adjuster _____
Company _____ Phone: _____

1. Industrial Commission File Number: _____
2. Employee's full name: _____
3. Employer's **full corporate name**: _____
Name of Insurer: _____
Self-insured or administered by: _____
4. Date of Injury: _____
5. Narrative description of injury or attach Form 19: _____

6. Compensation rate/Average weekly wage: \$ _____ /\$ _____
 Form 21 YES _____ NO _____ (please attach form)
 Form 60 YES _____ NO _____ (please attach form)
 Denied Claim YES _____ NO _____
 Form 61 YES _____ NO _____ (please attach form)
7. Total amount of Temporary Total Disability paid: \$ _____
8. Total amount of Medical Benefits paid: \$ _____
 Are there any unpaid medical bills? YES _____ NO _____ If so, how much \$ _____
9. Has Employee **returned to work** for the Employer YES _____ NO _____; or another employer? YES _____ NO _____ (please provide name) _____ If so, is the rate of pay the same or greater, and if less, please indicate the amount \$ _____
 Were they terminated or did they resign? _____
 Was a Form 28B filed? YES _____ NO _____ (please attach form)
10. Is a General Release needed? YES _____ NO _____
11. Overnight clincher to Employee or their attorney? YES _____ NO _____
12. Lump sum of settlement: \$ _____
 Advance: _____ (upon receipt of signed agreement)
13. Name and Address of Employee's attorney (**if no attorney, please furnish Employee's current address**): _____

*** **Please remember to include all medical records including rehabilitation records, physical therapy records and case management records, all IC forms, including form 25R and a detailed payment history of medicals paid to date, if any.**