INFORMED CONSENT

I understand and acknowledge that the settlement of my workers' compensation case by the Compromise and Release with the defendants, which are the insurance company and the employer, means that the insurance company and the employer will not be responsible for any future medical expenses and permanent disability payments after the date of signing the Compromise and Release.

I understand and acknowledge that I will be responsible for all future medical expenses related to my workers' compensation injury and that I will receive no further payments from the insurance company and may not seek reimbursement for any expenses from the insurance company or my employer.

I understand that I am giving up my right to keep medical treatment open. I have the right not to settle future medical treatment. In paragraph 6 of the Compromise and Release I am agreeing to pay all future medical expenses. I am taking full responsibility for all of my future medical treatment and the costs thereof. No further treatment will be supplied by defendants and no further expenses will be paid by defendants.

I understand that I do not have to settle my workers' compensation case in a way that included giving up my right to make defendants pay for future medical care for my work injuries. I choose to give up that right even though I am fully aware that my future medical expenses for my work injuries may be far greater than the settlement amount, and that my medical condition could worsen substantially, and the cost of medical care and/or medication required to treat my injuries may increase in the future.

I understand that I will not be able to go back to the defendant for additional treatment or disability payments even if unforeseen serious medical complications arise or future medical expenses far exceed the settlement amount. My medical condition could worsen and require a substantial increase in medical expenses, which will be entirely my responsibility.

I understand and acknowledge that any future medical expenses that are the result of my workers' compensation injury will have to be paid by me from the proceeds of the settlement. I know that I must make appropriate arrangements to ensure that I have sufficient funds available from the proceeds of the Compromise and Release to pay any future medical expenses to cure or relieve the effects of the workers' compensation injury.

I understand and acknowledge that I can receive the sums of the Compromise and Release through a structured settlement. The structured settlement may have tax advantages but that I would not have all of the proceeds from the Compromise and Release immediately available for my use. Knowing and understanding this I elect not to have a structured settlement.

I understand and acknowledge that my condition as the result of my workers' compensation injury may be considered a pre-existing condition for purposes of health care insurance and that a health insurance provider may not pay for medical expenses that are the result of or are a consequence of my workers' compensation injury.

I understand and acknowledge that the amount received by me from the Compromise and Release will be considered by the Social Security Administration and the Health Care Financing Administration in determining eligibility for any benefits I may be entitled to receive.

I understand and acknowledge that by receiving a lump sum settlement that monthly payments from Social Security Disability may be reduced.

I understand and acknowledge that Medicare may not pay for future medical expenses incurred as the result of my workers' compensation injury.

I understand and acknowledge that a sum may be deposited in a Medicare Set Aside Trust and that amounts may be withdrawn from this trust for medical expenses. I elect not to have a Medicare Set Aside Trust.

I will keep a careful accounting of all expenditures along with receipts for all amounts spent to cure or relieve the effects of my workers' compensation injury.

I understand and acknowledge that the terms of the Compromise and Release and the characterization of the amounts specified in the Compromise and Release are not binding on the Social Security Administration and that the Social Security Administration will make their own decision about the amount of my monthly payments and Medicare benefits. I understand and acknowledge that by agreeing to the Compromise and Release that my Social Security and Medicare benefits may be denied or reduced due to the amounts received from the Compromise and Release. I understand this risk and elect to proceed and settle my workers' compensation benefits by entering into the agreements as set forth in the Compromise and Release.

I have received and have read the pamphlet published by the Health Care Financing Administration entitled Medicare & You 2000.

Social Security Supplemental Security Income (SSI) is a benefit for those disabled persons who have limited income and resources. I understand and acknowledge that by agreeing to receive a lump sum settlement I may become ineligible for SSI benefits.

By signing this Informed Consent I acknowledge that I have read and understand all the terms of this Informed Consent and of the Compromise and Release. I further acknowledge that my attorney has discussed and explained this Informed Consent and the Compromise and Release and I am satisfied with the explanation. I further acknowledge that my attorney has advised me to consult with an attorney who specializes in social security benefits before agreeing to the Compromise and Release.

Date:______________ ____
Applicant

Approved as to form and content

Date:______________ ____
Attorney for Applicant

Date:______________ ____
Defendant