A Form Confidential Informational Letter for an Employee who is NOT Represented by Counsel

To: P&O Department
Virginia Workers' Compensation Commission

Name of Employee: _____

Re: Jurisdiction Claim No.: _____

I submit the following information in order to assist the Virginia Workers' Compensation Commission in determining whether to approve the proposed settlement of my pending workers' compensation claim. I understand that this information will be sealed and held in confidence by the Commission.

1. Date and injury of my injury or disease: _____

2. Age _____ years

3. Family status: _____ (married, single, divorced, widowed).

4. Name and ages of all dependents

Name	**Age**	**Relationship to Employee, i.e., son, daughter, or spouse**

5. Are you current working? (yes or no) (circle one) If yes, please provide the following:

Employer	**Weekly Wages and Date of Return to Work**

6. Please indicate the amount and source of any other income: (If you have no other income sources, please indicate "none" in the area below.)

Source	**Amount**

7. Are you able to read, write and understand the English language? (yes or no) (circle one).

   If you are not literate in English, state the name of the person reading and/or translating and explaining the settlement papers to you.

Name of Person	Address	Telephone Number

8. Are you currently receiving medical treatment? (yes or no) (circle one)

   Date of last medical treatment _____

   (a) Please describe the type of treatment and how often you visit your treating physician:

   (b) Identify the doctor(s) in the space below.

Name	Address	Telephone Number

   (c) Are there outstanding medical expenses? (yes or no) If yes, please state the name of the medical provider and the amount due.

9. Do you expect future medical expenses related to this injury? (yes or no). (circle one)

   If you anticipate future medical expenses, please describe below:

Type of Medical Expenses & Treatment	When or How Often Anticipated

10. Do you have any other insurance that will cover your medical expenses after the settlement? (yes or no) (circle one). Please give the name of the company.
    _____

11. What is your intended use of the settlement proceeds? _____

12. Are you receiving Social Security Disability benefits? (yes or no) (circle one) $_____

    If you are not receiving Social Security Disability benefits, do you intend to apply for such benefits? (yes or no) (circle one)

13. Are you currently receiving Medicare benefits? (yes or no) (circle one) If yes, for disability or old age retirement?

14. Because you are not required to settle your claim, please explain, in your own words in the space provided below, why you believe the settlement proposal is in your best interest.

Please provide the following: (required)

Employee's Signature:	**Address:**	**Telephone No.**	**Date:**

<u>Please attach additional sheets to supplement your answers to any of the above questions.</u>

Please return this completed form to:

P&O DEPARTMENT
Virginia Workers' Compensation Commission
333 E. Franklin Street
Richmond, VA 23219