WORKERS' COMPENSATION COMMISSION

# APPLICATION FOR LUMP SUM

**INSTRUCTIONS: This form is to be used ONLY for requesting a lump sum payment from a permanent disability award.**

**Claim Number:** _____

**Claimant's Name:** _____

**Employer:** _____

**Insurer:** _____

**Age** _____ **Marital Status** _____ **# of Dependents** _____ **Are you working?** No

**With/For Whom?** _____

**What are you making per week?** _____

**How much do you want in a lump sum?** _____ **Accident/Occupational Disease Date** _____

**Reason (Complete & detailed explanation)** ***Continue as attachment if needed***

**NOTE: All bills, papers, etc. in support of this request must be attached to this application before it can be considered for approval by the Commission.**

- ◯ **Employer/Insurer Consents to the Lump Sum**
- ◯ **Employer/Insurer Objects, Please Set for Hearing**
- ◯ **SIF Consents to the Lump Sum**
- ◯ **SIF Objects, Please Set for Hearing**

**I hereby certify that a copy of this request and its documentation has been sent to opposing counsel/parties.**

**REQUESTED BY:**

_____ _____ _____

**Full Name** **Date of Request**

☐ **CLAIMANT** ☐ **CLAIMANT'S ATTY** ☐ **EMPLOYER** ☐ **INSURER/EMPLOYER ATTY** ☐ **OTHER** _____

_____ _____

Street Address Telephone

_____ _____ _____

City State Zip Code

CLICK HERE TO CLEAR THE FORM



**10 East Baltimore Street • Baltimore, Maryland 21202-1641**