ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER

ATTENTION. Answer all questions. Attach a recent medical report. Internal# S0047589

Workers' Compensation Act **Yes** Occupational Diseases Act **No** Fatal case? **No** Date of death

ANTHONY KING Case# **20WC004712**
Employee/Petitioner

v.

CITY OF PEORIA Setting **Peoria**
Employer/Respondent

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Anthony King	[redacted]	[redacted]
Employee/Petitioner	Street address	City, State, Zip code
CITY OF PEORIA	**419 FULTON ST**	**PEORIA, IL 61602**
Employer/Respondent	Street address	City, State, Zip code

[redacted] [redacted]
[redacted] [redacted]

Dependents under age 18: [redacted]

Birthdate: [redacted]

Average weekly wage: **$1,237.32**

Date of accident: **8/6/2019**

How did the accident occur? **Lifting Logs**

What part of the body was affected? **Low Back**

What is the nature of the injury? **Disputed - Low back strain, fusion, subsequent fusion revision**

The employer was notified of the accident **orally.** Return-to-work date: **Disputed / 5/3/2021**

Location of accident: **Peoria** Did the employee return to his or her regular job? **No**

If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

Petitioner resigning from his employment and will seek employment elsewhere.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid for **58 6/7** weeks at the rate of **$824.88** /week.
The employee was temporarily totally disabled during the following period(s):

From	Through
1/28/2020	**3/14/2021**

Notes regarding temporary total disability benefits:

MEDICAL EXPENSES: The employer **has not** paid all medical bills. List unpaid bills in the space below.
See Terms of Settlement

PREVIOUS AGREEMENTS: Before the petitioner signed an Attorney Representation Agreement, the respondent or its agent offered in writing to pay the petitioner $ **N/A** as compensation for the permanent disability caused by this injury.
An arbitrator or commissioner of the Commission previously made an award on this case on **N/A** regarding
TTD $ **N/A** Permanent disability $ **N/A** Medical expenses $ **N/A** Other $ **N/A**

TERMS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee.
Respondent offers to pay and Petitioner agrees to accept the approved lump sum of $129,918.25, which, when using Petitioner's permanent partial disability rate of $742.39, represents 35% loss of use of the person-as-a-whole under Section 8(d)(2) of the Illinois Workers' Compensation Act, in full and final settlement of all claims for compensation arising out of the alleged August 6, 2019 accident and all claims for compensation arising out any other accident involving the low back occurring prior to the approval date of this contract, including any aggravation, exacerbation, sequela, or onset of symptoms prior to the date of this contract.

In regard to the alleged work accident on August 6, 2019, a serious dispute exists as to the nature and extent of the injuries and the causal connection between the aforementioned occurrences and any condition from which Petitioner is suffering, but to avoid further litigation, Respondent offers to pay and Petitioner agrees to accept the approved lump sum of $129,918.25. Please find attached in CompFile, three (3) IME reports authored by Dr. Kern Singh supporting the disputed nature of this claim. Effective October 22, 2021, through three (3) months following Petitioner's [redacted] procedure, scheduled for _____, Respondent agrees to pay temporary total disability benefits at a rate of $824.88 per week. Respondent agrees to pay any prior unpaid medical expenses through the approval date of the contract pursuant to the medical fee schedule for treatment related to the aforementioned accident and injury. Respondent agrees to pay all reasonable, necessary and related medical expenses pursuant to the fee schedule in accordance with Section 8(a) of the Illinois Workers' Compensation Act for one (1) year following the [redacted] surgery performed by Dr. Richard Kube. Petitioner and Respondent agree to waive the provisions of Section 8(a), at the conclusion of one (1) year from the date of Petitioner's [redacted] procedure. Petitioner and Respondent agree to waive the provisions of Section 19(h), and all provisions of the Illinois Workers' Compensation Act, except Respondent asserts its Section 5(b) lien interest to the extent a third-party recovery is made by the Petitioner. Petitioner states he is not receiving Social Security Disability Benefits nor has he applied for Social Security Benefits and he is not Medicare eligible.

The settlement of this claim is not an admission of liability on the part of Respondent. This settlement represents a compromise of all outstanding issues and claimed benefits on a completely disputed basis, and resolves all claimed benefits. This settlement contract is subject to the approval of Petition for Lump Sum and, if not approved, it is otherwise null and void. This settlement represents a purchase of peace between the parties. Petitioner and Respondent specifically intend for these provisions to be enforced.

Total amount of settlement	**$129,918.25**
Deduction: Attorney's fees	
Deduction: Medical reports, X-rays	
Deduction: Other (explain)	**$0.00**
Amount employee will receive	**$129,918.25**

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.*
I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights unless expressly reserved or left open for a specified period of time in the terms of settlement:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.

Signature of petitioner	Name of petitioner	Telephone number	Date

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PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

Signature of attorney

Date

Damon Young
Attorney's name

05328
IWCC Code #

DAMON YOUNG
2613 N KNOXVILLE

PEORIA, IL 61604
Firm name and address

(309) 682-3525
Telephone number

mandee@damonyounglaw.com
E-mail address

RESPONDENT'S ATTORNEY. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Signature of attorney

Date

Ryan W. Kitzhaber
Attorney's name

00980
IWCC Code #

HASSELBERG GREBE SNODGRASS
401 MAIN SUITE 1400

PEORIA, IL 61602
Firm name and address

(309) 637-1400
Telephone number

rkitzhaber@hgsuw.com
E-mail address

PMA Companies
Name of respondent's insurance or service company

ORDER OF ARBITRATOR OR COMMISSIONER:
Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case.