

COMPROMISE REVIEW APPLICATION

Personal information you provide may be used for secondary purposes (Privacy Law, s. 15.04(1)(m)).

WC Claim Number	Applicant Name	
Social Security Number	Applicant Mailing Address	
Injury Date	Applicant Attorney Name (if any)	
Applicant Attorney Mailing Address (if any)		
Employer Name	Insurance Company Name	
Employer Mailing Address		
Employer Name (if more than one)	Insurance Company Name	
Employer Mailing Address (if more than one)		
Briefly describe how injury occurred:		
Nature of Disability: (Indicate part of body injured and kind of disability as either strain or fracture)		
Date the order affirming the compromise was issued: _____		
List all reasons why the applicant feels compromise settlement was unjust:		
Where should hearing be scheduled?		
I will be ready for full hearing at any time after the following date: _____ / _____ / _____		
If not fully prepared for hearing, state reason here:		
Applicant Signature	Date Signed	

If it is claimed that greater disability has resulted than was anticipated at the time of settlement, application should be accompanied by physician's report, stating the extent of disability claimed.