TEXAS DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION
Send to the Division Field Office

CLAIM # ______________________________

CARRIER'S CLAIM # ______________________________

BENEFIT DISPUTE SETTLEMENT

1. Date of Proceeding (if applicable)	2. Docket Number and Location (if applicable)
3. Employee's/Beneficiary's Name	4. ☐ Employee/Beneficiary Assisted by Ombudsman ☐ Employee/Beneficiary Represented by
5. Employee's Social Security Number	6. Date of Injury
7. Employer's Name	8. ☐ Employer Assisted by Ombudsman ☐ Employer Represented by
9. Insurance Carrier's Name	10. Insurance Carrier Represented by

All settlements are subject to the pertinent provisions of the Texas Workers' Compensation Act, Texas Labor Code, Sections 408.005, 408.021, 408.185, and 410.029.

13. **THE PARTIES AGREE**

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Furthermore, the parties agree that the above referenced claimed injury is compensable, the insurance carrier is liable for the claim, and the employee is entitled to benefits. This settlement incorporates all prior oral and written agreements between the parties related to this claim. The employee's right to medical benefits as provided by the Texas Workers' Compensation Act, Texas Labor Code, Section 408.021 shall not be limited or terminated. THIS SETTLEMENT IS THE FINAL RESOLUTION OF ALL ISSUES IN THIS CLAIM AND THE PARTIES WAIVE THEIR RIGHTS TO SUBSEQUENT DIVISION PROCEEDINGS, OTHER THAN THOSE NECESSARY TO RESOLVE MEDICAL BENEFIT DISPUTES OR TO ENFORCE COMPLIANCE WITH THE TERMS OF THIS SETTLEMENT.

I have read or have had read to me by someone of my choice, understand and voluntarily agree to the terms of this agreement as stated above. Compliance Date _____________ . The agreement shall be fully complied with within five days of the approved agreement being received by the carrier, but, if the agreement includes a compliance date, that date will control.

Employee's/Beneficiary's Signature ______________________________ Date ____________

Employee/Beneficiary's Representative's Signature ______________________________ Date ____________

Employer Representative's Signature ______________________________ Date ____________

Carrier Representative's Signature ______________________________ Date ____________

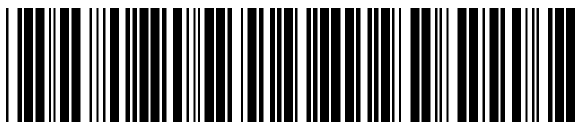
Authorized DWC Employee's Signature ______________________________ Date ____________

☐ Benefit Review Officer ☐ Contested Case Hearing Officer

APPROVED: ______________________________ Date ____________
Director of Hearings Signature

REJECTED: ______________________________ Date ____________
Director of Hearings Signature

REASONS FOR REJECTION WILL BE DELIVERED TO ALL PARTIES WITH THIS NOTICE



DWC FORM - 25
(Benefit Dispute Settlement)

All parties to a claim may sign a Benefit Dispute Settlement, DWC FORM-25, detailing the terms of a settlement. A settlement may not be made before maximum medical improvement is reached, and must adopt an impairment rating in accordance with the impairment rating guidelines set forth in the Texas Workers' Compensation Act, Texas Labor Code, Section 408.124. The employee's right to medical benefits provided in Section 408.021 shall not be limited or terminated. A settlement may not provide for a lump sum payment of any unaccrued income benefits except as provided in Section 408.128. A settlement must be reduced to writing on DWC FORM-25 and must be signed by all parties and submitted for approval to the Division field office handling the claim.

A settlement must establish that the carrier is liable for the claim, that the claim is compensable and that the employee is entitled to benefits; must include by reference all prior and written agreements between the parties; and must state that it is a final resolution on all issues in the claim with the parties waiving their rights to further Division proceedings other than those necessary to resolve medical benefit disputes or to enforce the terms of the settlement. It becomes effective and binding at the close of business on the date approved by the director of hearings **or** the sixteenth day after the date it was filed with the director of hearings, whichever is earlier. A party may withdraw acceptance of the settlement before its effective date.

This will be printed as a 4-part form with the original for the Division's claim record, the second copy for the employee/claimant, the third copy for the employee/claimant representative, if any, and the fourth copy for the insurance carrier representative. Additional copies, as needed, will be provided.

[Texas Workers' Compensation Act, Texas Labor Code, Section 408.005, Settlements and Agreements; Section 408.128, Commutation of Impairment Income Benefits; Section 408.185, Effect of Beneficiary Dispute; Attorney's Fees; Section 410.029, Resolution at Benefit Review Conference; Rules 147.1, 147.2, 147.3, 147.5, 147.6, 147.7, 147.8, 147.9, 147.10]