COMPROMISE AGREEMENT

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
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Fax: (608) 260-3056
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Notice: To expedite processing of compromises, provide current addresses of all parties involved.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

WC Claim Number	Employee Name	Employee Birth Date
Employee Social Security Number*	Employee Mailing Address (number, street, city, state, zip code)	
Date of Alleged Injury		
Employer Name	Employer Address (number, street, city, state, zip code)	
Insurance Company Name	Insurance Company Address (number, street, city, state, zip code)	

It is ☐ disputed ☐ undisputed that the employee was employed by the respondent employer.

Employee Earned Weekly Wage of **$**	Compensation Previously Paid Is **$**
The conceded disability is:	
There is a bona fide dispute between the parties as to whether the employee:	
Therefore the parties, subject to the approval of the Department of Workforce Development, agree to a Compromise Settlement as follows:	
NOTICE TO EMPLOYEE: The employee has the right to petition the Department of Workforce Development to set aside or modify this compromise agreement within one year of its approval by the department. The department may set aside or modify the compromise agreement. The right to request the department to set aside or modify the compromise agreement does not guarantee that the compromise will in fact be reopened.	
Employee Signature and Date Signed:	Witness Signature and Date Signed
Employee Attorney Signature and Date Signed:	Self-Insured Employer or Insurance Carrier Signature and Date Signed:

Date of Agreement:	**Attorney Fee: $** _____ **Percent** **Protect: $** _____ ☐ **Yes** ☐ **No** **Costs: $** _____ ☐ **Yes** ☐ **No**	**List:**