Mississippi Workers' Compensation Commission

1428 Lakeland Drive / Post Office Box 5300
Jackson, Mississippi 39296-5300
(601) 987-4200
http://www.mwcc.ms.gov

MWCC NO._____

Settlement Summary [1]

1.	Is this claim completely denied and no indemnity or medical has been paid?	Yes ☐ or No ☐
2.	Date of Injury?	_____
3.	Please indicate type of injury.	Schedule Member ☐ or Body as a Whole ☐
4.	Average Weekly Wage	_____
5.	Compensation Rate	_____
6.	Date of Maximum Medical Improvement	_____
7.	Impairment Rating (if applicable)	_____
8.	Does the Claimant have restrictions?	Yes (please attach) ☐ or No ☐
9.	Amount of TTD Paid?	_____
10.	Amount of PPD Paid?	_____
11.	If benefits have been paid, have the appropriate B-18s been filed?	Yes ☐ or No ☐
12.	Has Claimant returned to work for the Employer?	Yes ☐ or No ☐
13.	If yes, what is Claimant's new wage?	_____
14.	Are there any future medical needs?	Yes (please attach) ☐ or No ☐
15.	Has a medical cost projection been performed to support the settlement offer to close the medical portion of this claim?	Yes (please attach) ☐ or No ☐
16.	Claimant's Date of Birth	_____

[1] Please note that this document is not an official pleading and will not be made part of the electronic file.