Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
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https://dwd.wisconsin.gov/wc
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THIRD PARTY PROCEEDS DISTRIBUTION AGREEMENT

*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
Social Security Number*	Employee Mailing Address (number, street, city, state, zip code)
Injury Date	Employer Name
Insurance Claim Number	Employer Mailing Address (number, street, city, state, zip code)
Worker's Compensation Insurance Carrier or Self-Insured Employer	
Submitted By	Mailing Address (number, street, city, state, zip code)
Telephone Number	Email Address

_____, insurer of

_____ third party, and the above parties have

agreed to settle the liability of the tort-feasor for injury sustained on

The proceeds will be distributed according to the provisions of 102.29, Wisconsin Statutes, as follows:

1. $ total amount of third party settlement
2. $ to employee's attorney as cost of collection (fee & costs)
3. $ one-third of balance to employee
4. to worker's compensation insurance carrier or self-insured employer as reimbursement for payment of
   in compensation, and
   in medical expense
5. $ balance to employee which shall constitute a cushion or credit against any additional claim under worker's compensation

PLEASE NOTE: APPROVAL VOID IF PROCEEDS RESULT FROM UNINSURED OR UNDERINSURED MOTORIST PROVISION	Employee Signature
	Attorney Signature
Agreement Date	Worker's Compensation Insurance Carrier or Self-Insured Employer Signature

SETTLEMENT AND DISTRIBUTION OF PROCEEDS AS STATED ABOVE ARE APPROVED.

_____ _____

Date Signed Administrative Law Judge, Worker's Compensation Division