2. EMPLOYER FILE NUMBER:

3. EMPLOYER'S UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):

COMMUTATION OF BENEFITS OR COMPROMISE SETTLEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27 AUGUSTA, MAINE 04333

5. EMPLOYEE'S SOCIAL SECURITY NUMBER:

6. EMPLOYER NAME:	9. EMPLOYEE NAME:
Sherwin-Williams Co.	REDACTED
7. EMPLOYER ADDRESS: 101 Prospect Avenue Cleveland, OH 44115-1075	10. EMPLOYEE ADDRESS:
8. INSURER: Travelers Insurance Co.	11. DATE OF INJURY: 1/29/90 / 12. DESCRIPTION OF INJURY: respiratory distress

13. TYPE OF SETTLEMENT:

COMMUTATION ☐ COMPROMISE ☒ IF COMMUTATION, FORM WCB 10A IS REQUIRED IF COMPROMISE, SEE REVERSE FOR INSTRUCTIONS.

14. SUMMARY OF BENEFITS PAID TO DATE FOR THIS INJURY OR DEATH:

PHYSICIAN	$	DEATH BENEFIT	$
HOSPITAL	$ 1,187.62	FUNERAL	$
OTHER MEDICAL	$	LEGAL (EMPLOYEE RELATED)	$
WEEKLY COMPENSATION	$ 98,463.99	LEGAL (EMPLOYER RELATED)	$
PERMANENT IMPAIRMENT	$	OTHER	$
REHABILITATION	$	TOTAL PAID	$ 99,651.61

15. SUMMARY OF PROPOSED COMMUTATION:

PHYSICIAN	$	PERMANENT IMPAIRMENT	$
HOSPITAL	$	REHABILITATION	$
OTHER MEDICAL	$	DEATH BENEFIT	$
WEEKLY COMPENSATION	$	OTHER	$
		TOTAL PROPOSED SETTLEMENT	$ 50,000.00*

*$4000.00 payable to Sherwin-Williams for overpayment to EE

16. PREPARER'S NAME AND TITLE (TYPE OR PRINT):	SIGNATURE (FORM MUST BE SIGNED):	DATE:
Sheilah R. McLaughlin Attorney for Employer/Insurer	Sheilah R McLaughlin	10/6/94

RELEASE

17. EMPLOYEE/DEPENDENT:

I AM THE PERSON ENTITLED TO WORKERS' COMPENSATION BENEFITS ON ACCOUNT OF THIS INJURY OR DEATH. I HAVE READ THIS WORKSHEET AND ALL ATTACHMENTS. WHEN I RECEIVE THE AMOUNT SHOWN ABOVE AND THIS SETTLEMENT IS APPROVED BY THE HEARING OFFICER, I RELEASE THE EMPLOYER AND INSURER NAMED ABOVE FROM ALL FURTHER LIABILITY FOR THIS INJURY. I CONSENT TO THE SETTLEMENT.

SIGNATURE EMPLOYEE/DEPENDENT — SIGNATURE ATTORNEY — DATE

EMPLOYER/INSURER:

THE EMPLOYER/INSURER CONSENTS TO THE SETTLEMENT: YES ☒ NO ☐ Sheilah R McLaughlin SIGNATURE EMPLOYER/INSURER — 10/6/94 DATE

DECISION

18. THE REQUESTED SETTLEMENT (IS/IS NOT) (CIRCLE ONE) APPROVED. THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT THE SUM OF $ _____ IN A LUMP SUM SETTLEMENT ACCORDING TO THE WORKERS' COMPENSATION ACT. THE EMPLOYER/INSURER IS ORDERED TO PAY ALL OUTSTANDING COMPENSATION OBLIGATIONS INCURRED PRIOR TO THIS SETTLEMENT BY THE EMPLOYEE/DEPENDENT. THE EMPLOYER/INSURER IS ORDERED TO PAY THE ATTORNEY OF THE EMPLOYEE/DEPENDENT A FEE OF $ 5,000.00 ALL PENDING PETITIONS BASED ON THIS CLAIM ARE HEREBY DISMISSED.

HEARING OFFICER'S SIGNATURE — DATE