

RESOLUTION 2017-077 PASSED: JUNE 26, 2017

AUTHORIZING THE EXECUTION OF A WORKERS' COMPENSATION LUMP SUM PETITION AND ORDER IN THE AMOUNT OF \$31,530.43.

WHEREAS, the City of DeKalb is a Home-Rule Municipal Corporation governed by the applicable provisions of the Illinois Constitution and Illinois Municipal Code; and

WHEREAS, the City employs a variety of persons in a range of capacities and, from time to time when any such employee is injured in the line of duty, the City is responsible for certain claims and liabilities, and the City Council wishes to authorize execution of a lump sum petition and order relating to resolution of a Workers' Compensation Claim and further finds that such action is necessary and appropriate, and the conditions attached thereto protect the public, health, safety, welfare and morals.

NOW, THEREFORE, BE IT RESOLVED BY THE COUNCIL OF THE CITY OF DEKALB, ILLINOIS:

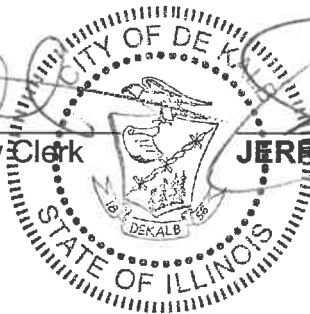
The City Manager or designee is authorized and directed to execute a lump sum petition and order contemplating the settlement for a pending Workers' Compensation Claim with Kevin Ferrigan, contemplating the payment of all outstanding medical bills associated with his compensable injury, and also contemplating the payment of a permanent partial disability lump sum payment in the amount of Thirty-One Thousand, Five Hundred Thirty Dollars and Forty-Three Cents (\$31,530.43), subject to approval by the Illinois Workers' Compensation Commission (IWCC), to thereafter seek such IWCC approval and to thereafter comply with such settlement.

PASSED BY THE CITY COUNCIL of the City of DeKalb, Illinois, at a Regular meeting thereof held on the 26th day of June, 2017, and approved by me as Mayor on the same day. Passed by a 7-0-1 Omnibus roll call vote under the Consent Agenda. Aye: Finucane, Marquardt, Fagan, Noreiko, Verbic, Faivre, Smith. Nay: None. Absent: Jacobson.

ATTEST:


RUTH A. SCOTT, Deputy City Clerk


JERRY SMITH, Mayor



**ILLINOIS WORKERS' COMPENSATION COMMISSION
SETTLEMENT CONTRACT LUMP SUM PETITION AND ORDER**

ATTENTION. Please type or print. Answer all questions. File four copies of this form. Attach a recent medical report.

Workers' Compensation Act Occupational Diseases Act Fatal case? No Yes Date of death _____

KEVIN H. FERRIGAN
Employee/Petitioner

Case # **15 WC 35659**
and
15 WC 35660

v.

CITY OF DE KALB
Employer/Respondent

Setting **Geneva Arb Flores**

To resolve this dispute regarding the benefits due the petitioner under the Illinois Workers' Compensation or Occupational Diseases Act, we offer the following statements. We understand these statements are not binding if this contract is not approved.

Kevin H. Ferrigan

Employee's name

Street address

City, State, Zip code

City of De Kalb

200 S. Fourth St

DeKalb IL 60115

Employer's name

Street address

City, State, Zip code

Date of accident **June 1, 2015 and September 27, 2015 and April 25, 2016**

How did the accident occur? June 1, 2015: while servicing signal box at W. Taylor and Annie Glidden Rd, stepped in uneven ground and twisted left ankle. September 27, 2015 the petitioner stepped on an uneven surface in low light conditions during swat team exercises and twisted left ankle April 23, 2016: after making arrest in the 1900 block of W. Sunflower, while walking across a parkway in the dark and stepped in a hole, twisting the left ankle.

What part of the body was affected? left ankle in all three accidents

What is the nature of the injury? Left ankle sprain anterior talofibular ligament and peroneus brevis tendon tear.

The employer was notified of the accident orally in writing

Return-to-work date **June 2, 2015; Feb 22, 2016; April 26, 2016**

2016; April 26, 2016

Location of accident **De Kalb, IL** Did the employee return to his or her regular job? Yes No

If not, explain below and describe the type of work the employee is doing, the wage earned, and the current employer's name and address.

TEMPORARY TOTAL DISABILITY BENEFITS: Compensation was paid full salary for all time lost from work.

The employee was temporarily totally disabled from **October 23, 2015 to February 22, 2016**

MEDICAL EXPENSES: The employer has has not paid all medical bills. List unpaid bills in the space below.

All medical costs known and proven to have been work related have been paid by or for the respondent according to the Illinois Workers' Compensation Fee Schedule for dates of service through the date of maximum medical improvement April 26, 2106.

PREVIOUS AGREEMENTS: Before the petitioner signed an *Attorney Representation Agreement*, the respondent or its agent offered in writing to pay the petitioner \$ **0.00** as compensation for the permanent disability caused by this injury.

An arbitrator or commissioner of the Commission previously made an award on this case on **None** regarding

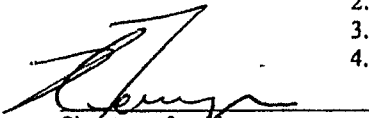
TTD \$ **none** Permanent disability \$ **0.00** Medical expenses \$ **none** Other \$ **none**

TERMS OF SETTLEMENT: Attach a recent medical report signed by the physician who examined or treated the employee. The respondent has offered and the petitioner has agreed to accept, a lump sum of \$31,530.43, being compensation for all work related injuries sustained by the Petitioner in the employment of the City of DeKalb, upon the approval of this settlement contract by an Arbitrator of the Illinois Workers Compensation Commission. This is a full and complete compromise settlement of any and all claims for temporary total, temporary partial, permanent partial or permanent total disability benefits and all maintenance and rehabilitation benefits under the Workers' Compensation Act, including all claims for the cost of first aid, medical, surgical and hospital services and claims for compensation and other benefits on account of any and all injuries, disabilities, and all consequences, either known or unknown, arising out of the herein described alleged accidental injuries and all consequences of the injuries, having occurred on or about June 1, 2015 and September 27, 2015 and April 25, 2016 and any other date of employment with the City of DeKalb. This is a compromise settlement and is mutually understood and intended to be a purchase of peace, and to conclude litigation. Review of this settlement or review of this case for any claims of an increase of disability under Section 19(h), or or medical costs under Section 8(a) and 8.2 of the Illinois Workers' Compensation Act are all hereby expressly waived. This settlement represents: loss of use of the left foot to the extent of 25 % The petitioner at the time of settlement is engaged in a substantial gainful employment with respondent. The petitioner at the time of settlement has no reason to expect to be a claimant for social security disability benefits within the next 30 months. The petitioner at the time of settlement has no reason to expect to be a medicare beneficiary within the next 30 months.

Total amount of settlement	\$ <u>31,530.43</u>
Deduction: Attorney's fees	\$ <u>6,306.09</u>
Deduction: Medical reports, X-rays	\$ <u>75.00</u>
Deduction: Other (explain)	\$ _____
Amount employee will receive	\$ <u>25,149.34</u>

PETITIONER'S SIGNATURE. *Attention, petitioner. Do not sign this contract unless you understand all of the following statements.* I have read this document, understand its terms, and sign this contract voluntarily. I believe it is in my best interests for the Commission to approve this contract. I understand that I can present this settlement contract to the Commission in person. I understand that by signing this contract, I am giving up the following rights:

1. My right to a trial before an arbitrator;
2. My right to appeal the arbitrator's decision to the Commission;
3. My right to any further medical treatment, at the employer's expense, for the results of this injury;
4. My right to any additional benefits if my condition worsens as a result of this injury.



Signature of petitioner


Kerri Fernan
Name of petitioner (please print)

Telephone number

7/14/17
Date

PETITIONER'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. Based on the information reasonably available to me, I recommend this settlement contract be approved.

FEIN: 20-1447497



Signature of attorney

July 10, 2017
Date

Robert T. Bernat #3130
Attorney's name and IC code # (please print)
Bernat and Bernat P.C.
Firm name
120 S. La Salle St Suite 1600
Street address
Chicago IL 60603
City, State, Zip code
312-859-4000 rbernat@bernatlaw.com
Telephone number E-mail address

RESPONDENT'S ATTORNEY. I attest that any fee petitions on file with the IWCC have been resolved. The respondent agrees to this settlement and will pay the benefits to the petitioner or the petitioner's attorney, according to the terms of this contract, promptly after receiving a copy of the approved contract.

Robert T. Newman July 5, 2017
Signature of attorney or agent Date

Robert T. Newman, #481
Attorney's name and IC code # or agent (please print)

Maciorowski, Sackmann & Ulrich, LLP
Firm name

105 W. Adams St Suite 2200
Street address

Chicago, IL 60603
City, State, Zip code


312-627-0631
Telephone number

rnewman@msulaw.com
E-mail address

CCMSI
Name of respondent's insurance or service company (please print)

Illinois Workers Compensation Commission
pursuant to the provisions of the
Workers' Compensation and Workers'
Occupational Disease Acts

JUL 27 2017


Arbitrator

ORDER OF ARBITRATOR OR COMMISSIONER:
Having carefully reviewed the terms of this contract, in accordance with Section 9 of the Act, by my stamp I hereby approve this contract, order the respondent to promptly pay in a lump sum the total amount of settlement stated above, and dismiss this case. IC5 page 2