

**VOLUNTARY PAYMENT FORM**  
 Michigan Department of Licensing and Regulatory Affairs  
 Workers' Compensation Agency/Board of Magistrates  
 P.O. Box 30016, Lansing, MI 48909

(Personal Service) (Mailed)  
 \_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
 Magistrate/Mediator (Please print)

Plaintiff	Defendant
Plaintiff's Social Security Number	Date of Injury

The plaintiff and defendant agree that the plaintiff's Application for Mediation or Hearing is withdrawn. The defendant agrees to pay benefits on a voluntary basis in accordance with the following:

- a. Weekly benefit rate \$ \_\_\_\_\_
- Less benefits to be coordinated \$ \_\_\_\_\_
- Subtotal \$ \_\_\_\_\_
- Plus supplemental benefit \$ \_\_\_\_\_
- TOTAL** \$ \_\_\_\_\_
- Benefits to be paid for the period from \_\_\_\_\_ through \_\_\_\_\_
- b. Medical expenses to be paid?  Yes  No  
 If yes, to whom? \_\_\_\_\_
- c. Reimbursement to group carrier?  Yes  No
- d. Atty. fee to be charged Percent \_\_\_\_\_% Amount \$ \_\_\_\_\_  
 Atty. Fed. I.D.# \_\_\_\_\_
- e. Amount of interest to be paid \$ \_\_\_\_\_
- f. Additional agreements (attach additional sheets if necessary)

Neither the payment of compensation nor the accepting of same by the employee or his/her dependents shall be considered as a determination of the rights of the parties under this Act.

All benefits become due and payable on the day of personal service or the mailing date.

_____	_____
Plaintiff	Defendant
_____	_____
Representative of Plaintiff	Representative of Defendant
_____	_____
Date	Magistrate/Mediator

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act 418.222; 418.223; 418.847; 408.33(2)(b)  
 Completion: Voluntary  
 Penalty: None