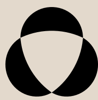

Washington State Department of Labor & Industries

Third Party Election Form

Injured by a third party? You have legal options. Protect your rights.

Injured Worker Name	Claim Number
Email Address	

☐ **My address has changed.** *Check the box and write your **NEW** address below.*

Injured Worker's Mailing Address	City	State	Zip

Make your choice. Then sign and date in the appropriate place.

Option A

☐ **My attorney or I will seek to recover my personal injury damages.**

I understand that I must notify the Department of Labor & Industries if or when I file a lawsuit. If I choose to hire an attorney, I give L&I permission to communicate with him/her. I also understand that if I receive money as a result of a legal settlement or award, I must repay my workers' compensation benefits to L&I. Before I settle my case, or allocate economic and non-economic damages in a settlement, I must obtain L&I's written approval if the settlement will result in the Department receiving less than the amount of benefits paid, or estimated to be paid. If I have an attorney, I have provided his/her name, address and telephone numbers below.

Signature X			Date
Attorney's Name	Attorney's Address		
Attorney's Phone ( )	City	State	Zip

Option B

☐ **I authorize L&I to consider recovery of my personal injury damages.**

I give up my right to take legal action against the third party to recover damages, both economic and non-economic, on my own or with an attorney. I give this right to L&I and I understand that L&I may choose to not take legal action. I authorize L&I to release information from my claim file for these purposes. I have not received any money from any third party I believe is responsible for my injury.

Signature X	Date

☐ **No third party responsibility.** I do not believe a third party was responsible for my injury. I have explained why in "Description and Location of Accident" box below.

Signature X	Date

Third party information

Name of Third Party	Address	City	State	Zip	Phone ( )

Accident information

Description and Location of Accident	Date of Accident	Time of Accident ☐ AM ☐ PM

Name of Witness to Accident	Address	City	State	Zip	Phone ( )

For a motor-vehicle accident, provide the third party's auto insurance information.

Name of Insurance Company	Policy Number	Claim Number

F249-008-000 [08-2014]

After you complete and sign this form, detach this form from the accompanying brochure. Fold it with the **Business Reply Mail** side facing out. Use tape to close the form, and then mail. No postage is needed.