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

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.