

BEFORE THE IOWA WORKERS' COMPENSATION COMMISSIONER

No(s): _____

vs.

Claimant(s),

Employer,

Insurance Carrier,

Defendant(s).

Application for
Payment of Benefits
Under Iowa Code § 85.21

1. The employer or insurance carrier, _____, without admitting liability, hereby applies for and consents to an order of the Iowa Workers' Compensation Commissioner under Iowa Code section 85.21 requiring the payment of weekly benefits and authorized medical benefits under Iowa Code chapter 85, 85A, or 85B.
2. Payment of these benefits shall be subject to termination under Iowa Code section 10A.315.
3. Date of injury: _____
4. Claimant's address: _____
5. Employer's address: _____
6. Insurance carrier's address: _____
7. Other parties to dispute: _____

Signature of Attorney for Defendant(s) - or - Representative of Defendant(s)

Full Name: _____

Law Firm/Entity: _____

Telephone: _____

Email: _____

Mailing Address: _____



Iowa Department of **INSPECTIONS APPEALS & LICENSING**
Division of **WORKERS' COMPENSATION**

Application for Payment of Benefits
Form 14-0037 — Last Updated July 2023
www.IowaWorkComp.gov

