New Jersey Department of Labor and Workforce Development **DIVISION OF WORKERS COMPENSATION** WC-60 (R-6-07)	**APPLICATION FOR COMMUTATION** **(WC-S-7)**	C.P. NO. _____ DATE FILED _____

PETITIONER	NAME	ATTORNEY FOR PETITIONER	TAX IDENTIFICATION NUMBER
	COUNTY OF RESIDENCE: ADDRESS		NAME
			ADDRESS
	TELEPHONE (Area Code)		TELEPHONE (Area Code)

VS

RESPONDENT	NAME	INSURANCE CARRIER	NAME ☐ SELF-INSURED ☐ NOT-COVERED
	COUNTY OF RESIDENCE: ADDRESS		CLAIM FILE No. ADDRESS

TYPE OF HEARING	PLACE OF HEARING	HEARING OFFICIAL	DATE OF JUDGMENT	DATE OF ACCIDENT
☐ Formal ☐ Informal				

SEX	AGE	MARITAL STATUS	CITIZEN
			☐ Yes ☐ No

DEPENDENTS NAMES	AGES	SEX

REGULAR OCCUPATION	PRESENT OCCUPATION	LOCATION OF PRESENT EMPLOYMENT
WEEKLY WAGE $	**TOTAL FAMILY INCOME** $	**FIXED FAMILY NON-DEFERABLE EXPENSES** $

Period of Temporary: _____ to _____ or _____ weeks, or $ _____

Period of Permanency Paid: _____ % of _____ or _____ weeks, or $ _____

Balance Due on Award: _____ Amount Requested for Commutation: _____

REASON FOR REQUEST FOR COMMUTATION: (Use additional sheets if necessary)
PLEASE SUBMIT ANY COMMITMENTS TO SUBSTANTIATE YOUR REQUEST.

_____
Signature of Applicant

(FOR DIVISION OF WORKERS' COMPENSATION USE ONLY)

Report of Investigation or Remarks (Attach Rider, if necessary)

(FOR DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT USE ONLY)

☐ **APPROVED**

☐ **DISAPPROVED** _____ Date: _____

JUDGE