

HAPESHIS LAW, LLC

Shelby G. Hapeshis  
Shelby@hapeshislaw.com

November 1, 2017

(VIA FACSIMILE & U.S. MAIL)  
Daniel E. Shearouse, Clerk of Court  
Supreme Court of South Carolina  
Post Office Box 11330  
Columbia, SC 29211

RECEIVED  
NOV 03 2017  
S.C. SUPREME COURT

Re: **Claim Settled**  
Martha Perez v. Alice Manufacturing  
Appellate Case No. 2017-001993

Dear Mr. Shearouse:

Because the parties have agreed to settle this matter, we would request a stay of the timeframe for future filings for two weeks until we received the signed documents from the South Carolina Workers Compensation Commission.

Sincerely,

Shelby G. Hapeshis

SGH/ea

cc: W. Grady Jordan

5500

RECEIVED

BEFORE THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION NOV 03 2017

Martha Perez, )  
 )  
 Employee/Claimant, )  
 )  
 -vs- )  
 )  
 Alice Manufacturing )  
 )  
 Employer, )  
 )  
 and )  
 )  
 Great American Alliance Insurance Co., )  
 )  
 Carrier, )  
 )  
 Defendants. )

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W.C.C. FILE NOS. 1321689  
 1321387  
 1407915

S.C. SUPREME COURT

**SETTLEMENT AGREEMENT  
 AND RELEASE**

The Claimant, Martha Perez, while in the course of employment of Alice Manufacturing claimed bodily injuries to her chin and back in alleged accidents arising out of and in the course of her employment on or about April 11, 2013 (WC No. 1321689), August 08, 2013 (WC No. 1321387) and May 19, 2014 (WC No. 1407915), in the County of Pickens, State of South Carolina.

At the time of the alleged accidents aforementioned, the Claimant and the Employer were subject to the Workers' Compensation Law of South Carolina (hereinafter called "Act") and the Carrier was the Employer's insurer under said Act.

The Defendants paid disability and medical benefits as shown on the Status Report and Compensation Receipts (Form 19).

The employee is represented by W. Grady Jordan, Esquire of Smith, Jordan, Lavery & Lee, PA in Easley, South Carolina. The employer and carrier are represented by Shelby G. Hapeshis, Esquire of Hapeshis Law, LLC in Irmo, South Carolina. Disputes exist between the parties as to:

*W. Grady Jordan*  
*Shelby G. Hapeshis*  
*MP*

Whether or not employee sustained a compensable injury by accident, if so, extent of any injury; Claimant's entitlement to further medical care; Whether or not employee has reached maximum medical improvement; Carrier's entitlement, if any, to credit for overpayment of temporary total; Claimant's entitlement to further payments of temporary disability and the extent of any causally related permanent disability, if any.

The parties hereto now advise that, in view of the aforementioned disputes, an agreement has been reached to settle this matter in its entirety, pursuant to Section 42-9-390.

Under the proposed settlement, the Defendants have agreed to pay, and the Claimant has agreed to accept, the sum of \$76,000.00 (**Seventy Six Thousand Dollars and 00/100**) in full settlement and satisfaction of every liability under the Act growing out of or in any way connected with any injury and/or accident occurring on or about April 11, 2013, August 08, 2013, May 19, 2014; further, claimant states there are no other workers' compensation claims, reported or unreported, at any other time prior to this agreement.

As an integral part of this settlement agreement, it is expressly understood and agreed that the Defendants have paid all medical expenses for which they are liable and that the Claimant is responsible for any and all other medical expenses of whatsoever nature and the Defendants shall have no liability therefor. It is further understood and agreed that these are doubtful and disputed claims and nothing contained herein shall be construed as an admission of liability by the defendants, which was and is denied.

The Claimant hereby asserts that she has been fully advised of all her rights under the South Carolina Workers' Compensation Act, and is of the opinion that the proposed settlement is reasonable and fair and in this opinion, the Claimant's attorney concurs. The Claimant hereby asserts that she recognizes that her consent to, and the approval of, this settlement is a final determination and adjudication of all benefits under the South Carolina Workers' Compensation

Act, growing out of, or in any way connected with, any known injury and/or accident occurring on or about April 11, 2013, August 08, 2013, May 19, 2014.

NOW, THEREFORE, in consideration of the payment to the Claimant of the sum of **\$76,000.00 (Seventy Six Thousand Dollars and 00/100)**, and in further consideration of the mutual covenants, stipulations, and releases herein contained, the Claimant hereby releases and discharges Alice Manufacturing and Great American Alliance Insurance Company, and binds Claimant's heirs, executors, administrators, dependents, next of kin, privies, and assigns under the Act and agrees to release, discharge, defend, and indemnify Alice Manufacturing and Great American Alliance Insurance Company and their respective agents, servants, insurers, physicians, privies, and their successors, from any and all debts, claims, demands, causes of action, rights of action, and liabilities whatsoever of any known injury and/or accident on or about April 11, 2013, August 08, 2013, May 19, 2014 including, but not limited to, any right which the Claimant might otherwise have to demand benefits for disability, disfigurement, bodily impairment, medical treatment, medicine or drugs, prosthetic devices, lost time or death, under the Act or otherwise and specifically including any right which Claimant might otherwise have to demand further benefits by way of compensation or medical care under the Act because of a change in condition hereinafter (which is expressly waived, released and renounced) whether or not arising out of, or directly or indirectly in any way conceivably attributable to any known injury and/or accident occurring on or about April 11, 2013, August 08, 2013, May 19, 2014, further, claimant states there are no other workers' compensation claims, reported or unreported, at any other time prior to this agreement.

The settlement proceeds of Seventy Six Thousand and 00/100ths (**\$76,000.00**) Dollars shall be allocated as follows: Twenty Five Thousand and 00/100ths (**\$25,000.00**) Dollars as attorneys fees; Eight Hundred Forty Two and 21/100ths (**\$842.21**) Dollars as costs; and the remainder of Fifty Thousand One Hundred Fifty Seven and 79/100ths (**\$50,157.79**). Dollars at

the rate of One Hundred Thirty Five and 27/100ths (\$135.27) Dollars per month for a period of 370.80 months pursuant to '42-9-10 and '42-9-30 of the 1976 Code of Laws as interpreted by the South Carolina Supreme Court in Utica Mohawk Mills v. Orr, 227 S.C. 226, 97 S.E.2d 589 (1955) and by the Third Circuit Court of Appeals in Sciarotto v. Bowen, 837 F.2d 135 (3rd Cir. 1988).

It is expressly understood that the defendant takes no position and makes no representation as to the requested allocation of the proposed settlement sum as set forth hereinabove and that the proposed allocation in no way affects the absolute release of the defendant.

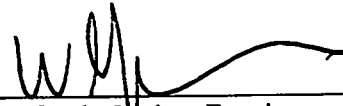
The parties have taken into consideration Social Security Disability and Medicare's potential interest in the resolution of the claim and there is no interest to their knowledge.

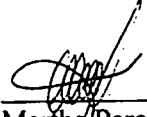
This Agreement shall not be subject to review, modification, or amendment by the Commission or the Courts of this State and is res judicata.


IN WITNESS WHEREOF, the parties hereto have caused this instrument to be executed as of \_\_\_\_\_, 2017.

WITNESSED AND APPROVED:

In the presence of:

  
\_\_\_\_\_  
W. Grady Jordan, Esquire  
Attorney for Claimant

  
\_\_\_\_\_  
Martha Perez, Claimant

  
\_\_\_\_\_  
Shelby G. Hapeshis, Esquire  
Attorney for Employer/Carrier

Columbia, South Carolina  
Date: \_\_\_\_\_

South Carolina Workers' Compensation Commission  
 1333 Main Street, Suite 500  
 P.O. BOX 1715  
 Columbia, SC 29202-1715  
 (803) 737-5723



WCC File #: 1321387  
 Carrier File #: 564593555  
 Carrier Code #: 185  
 Employer FEIN #: 570516664

Claimant's Name: Martha Perez Employer's Name: Alice Manufacturing  
 Address: 202 Forest Drive Address: P O Box 369  
 City: Liberty State: SC Zip: 29657 City: Easley State: SC Zip: 29641  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Insurance Carrier: Great American/Strategic Comp  
 Preparer's Name: Steve Anthony Law Firm: \_\_\_\_\_ Preparer's Phone #: 770 225 3564

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.	<u>67</u>	<u>6/6/2016</u>	<u>10/6/2017</u>	\$ <u>26,101.19</u>
2. Number of Weeks T.P.	_____	_____	_____	\$ _____
3. Number of Weeks P.P.	_____	_____	_____	\$ _____
4. Disfigurement	_____	_____	_____	\$ _____
5. Agreement and Final Release				\$ <u>76,000.00</u>
<b>Total Compensation Paid</b>				\$ <u>102,101.19</u>
6. Total Medical Benefits* Paid				\$ <u>5,270.42</u>
7. Funeral Benefits				\$ _____

Case Denied

Date of Injury: 8/8/2013  
 (m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: [Signature]  
 Claimant

By: [Signature]  
 Employer's Representative

10/31/17  
 Date  
 (m/d/yyyy)

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: \_\_\_\_\_

Report of Additional Fees and Recoupment

- A. Carrier Reimbursement by Third Party \$ \_\_\_\_\_
- B. Attorney's Fee Paid by Employer \$ \_\_\_\_\_
- C. Attorney's Fee Paid by Claimant \$ \_\_\_\_\_  
 (Non-contingent fees only)

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. \* Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.



Claimant's Name: Martha Perez Employer's Name: Alice Manufacturing  
 Address: 202 Forest Drive Address: P O Box 369  
 City: Liberty State: SC Zip: 29657 City: Easley State: SC Zip: 29641  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Insurance Carrier: Great American/Strategic Comp  
 Preparer's Name: Steve Anthony Law Firm: \_\_\_\_\_ Preparer's Phone #: 770 225 3564

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.	_____	_____	_____	\$ _____
2. Number of Weeks T.P.	_____	_____	_____	\$ _____
3. Number of Weeks P.P.	_____	_____	_____	\$ _____
4. Disfigurement	_____	_____	_____	\$ _____
5. Agreement and Final Release	_____	_____	_____	\$ _____
<b>Total Compensation Paid</b>				\$ <u>0.00</u>
6. Total Medical Benefits* Paid	_____	_____	_____	\$ <u>3,853.37</u>
7. Funeral Benefits	_____	_____	_____	\$ _____

paid in combination with  
 WC No. 1321387

Case Denied

Date of Injury: 4/11/2013  
 (m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: [Signature]  
 Claimant

By: [Signature]  
 Employer's Representative

10/31/17  
 Date  
 (m/d/yyyy)

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: \_\_\_\_\_

Report of Additional Fees and Recoupment

A. Carrier Reimbursement by Third Party	\$ _____
B. Attorney's Fee Paid by Employer	\$ _____
C. Attorney's Fee Paid by Claimant (Non-contingent fees only)	\$ _____

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. \* Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.



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 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Insurance Carrier: Great American/Strategic Comp  
 Preparer's Name: Steve Anthony Law Firm: \_\_\_\_\_ Preparer's Phone #: 770 225 3564

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.	_____	_____	_____	\$ _____
2. Number of Weeks T.P.	_____	_____	_____	\$ _____
3. Number of Weeks P.P.	_____	_____	_____	\$ _____
4. Disfigurement	_____	_____	_____	\$ _____
5. Agreement and Final Release	_____	_____	_____	\$ _____
<b>Total Compensation Paid</b>				\$ <u>0.00</u>
6. Total Medical Benefits* Paid	_____	_____	_____	\$ <u>1,801.44</u>
7. Funeral Benefits	_____	_____	_____	\$ _____

Case Denied

Date of Injury: 5/19/2014  
 (m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: [Signature]  
 Claimant

By: [Signature]  
 Employer's Representative

10/31/17  
 Date (m/d/yyyy)

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: \_\_\_\_\_

Report of Additional Fees and Recoupment

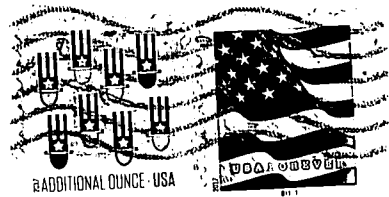
A. Carrier Reimbursement by Third Party	\$ _____
B. Attorney's Fee Paid by Employer	\$ _____
C. Attorney's Fee Paid by Claimant (Non-contingent fees only)	\$ _____

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. \* Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.

Hapeshis Law Firm  
P.O. Box 4247  
Irmo, SC 29063

COLUMBIA SC 290

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Daniel E. Shearouse, Clerk of Court  
Supreme Court of South Carolina  
Post Office Box 11330  
Columbia, SC 29211

29211-133030



