Ohio | Bureau of Workers' Compensation

Settlement Agreement and Application for Approval of Settlement Agreement

for state-fund claims only

Instructions

- You must file this form when requesting a settlement. In addition:
  - o If you are an injured worker receiving permanent total disability (PTD) benefits, an injured worker who is requesting consideration of PTD benefits or a claimant currently receiving death benefits, you also must complete and submit:

    – *Medical History and Disclosure* (C-242) with supporting medical documentation;

    – *PTD-Death Settlement Acknowledgment and Waiver* (C-243) if applying for full settlement or;

    – *Indemnity Only Settlement Acknowledgment and Waiver* (C-245) if applying for an indemnity only settlement.
- **You must submit required information listed above to avoid delays in processing and/or disapproval of the application.**
- BWC may request that an injured worker submit the C-242 with supporting medical documentation for claims other than those listed above.
- By filing this application, the injured worker and the employer understand BWC will suspend all unresolved claim issues, except issues related to temporary total benefits, PTD benefits and alternative dispute resolutions, which BWC will continue to process.
- This application can only be used to settle a claim(s) with a single employer. If you wish to settle claims that are assigned to a different employer, you must file a separate application.
- Use a *Self-insured Joint Settlement Agreement and Release* (SI-42) to pursue a settlement with a self-insuring employer.
- Submit this form, via fax to 1-866-336-8352, or send it to your local BWC customer service office.

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Claimant information			
Claimant name			Date of birth
Address	City	State	ZIP code
Email address			Phone number ☐ Home ☐ Cell

Claimant representative information		
Claimant representative name	Fax number	Phone number
Email address	Representative ID number	

Employer of record information			
Employer name	Risk number	Fax number	Phone number
Email address			

Employer representative information		
Employer representative name	Fax number	Phone number
Email address	Representative ID number	

All claims for which the claimant and above named employer make application to BWC for approval of settlement.

Claim number	**Please select type of settlement being requested** (select only full or partial).	**Requested settlement amount**
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	
	☐ Full settlement ☐ Indemnity only settlement	

Clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable, describe briefly why you want to settle your claim(s). This information is **REQUIRED** pursuant to Ohio Revised Code (ORC) 4123.65.

Medical Information

If you are an injured worker, are you receiving medical treatment at this time for any of the claims listed above?
☐ Yes ☐ No

Special notice to medicare beneficiaries

Are you receiving, or have you applied for Medicare benefits or filed an appeal on a denied application?
☐ Yes ☐ No

If yes, Medicare does not pay medical bills for conditions covered by your workers' compensation claim. If a settlement of your workers' compensation claim is reached, and the settlement allocates certain amounts for future medical expenses, Medicare does not pay for those services until medical expenses related to your workers' compensation claim equal the amount of the lump sum settlement allocated to future medical expenses. For additional information, please call the Medicare coordination of benefits contractor at 800-999-1118.

Employment status information

If you are the injured worker, you are required to answer the following questions:

Are you still an employee of the employer listed above (the injury employer)? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No

If yes, what is your present occupation: _____

Name of the employer: _____

What are your present wages? Per hour: _____ Per week _____

If no, are you retired? ☐ Yes ☐ No

Employer/Attorney signature or claimant acknowledgment of exception

Instructions to the claimant:
Pursuant to Section 4123.65(A) of the Ohio Revised Code (ORC), the employer's signature is not required on this settlement application if the employer is no longer doing business in Ohio, or the employer is still doing business in Ohio, however:

- The claim(s) involved in the settlement application is out of the employer's experience and the claimant is no longer employed with the employer;
- The employer has failed to pay premiums as required by Section 4123.35 of the ORC.

☐ **Check here if the employer's signature has not been provided due to one of these exceptions.**

Instructions to the employer:
Please check one of the following boxes and sign below. Your signature does not waive your right as the employer to withdraw consent to the settlement by providing written notice to the employee and the BWC administrator within 30 days after the administrator issues the approval of the settlement agreement.

☐ A. The employer is supportive of and agreeable to a settlement up to the amount listed on the front of this application.
☐ B. The employer does not agree with the requested settlement terms but will participate with the BWC in the negotiation process.
☐ C. The employer is supportive of and agreeable to settlement of the claims listed on the front of this application. However, the employer will not participate in the settlement negotiations and requests the BWC to negotiate the settlement on behalf of the employer.
☐ D. The employer is not agreeable to settlement of the claim(s) listed on the front of this application.

Settlement of a state-fund claim(s) when the employer is now self-insuring:
If the claim to be settled is a state-fund claim(s), and the employer is now self-insuring, BWC charges the self-insuring employer dollar for dollar for any portion of the settlement attributed to past, present or future Disabled Workers' Relief Fund (DWRF) liability. By signing this agreement, the self-insuring employer acknowledges its obligation to reimburse BWC for the portion of the settlement amount allocated to DWRF costs of the above-referenced claim(s). BWC will bill the DWRF portion of the settlement to the self-insuring employer, even if the claimant has not yet been determined to be permanently and totally disabled or currently eligible for DWRF benefits.

Employer signature	Title	Date

Employer attorney signature	Attorney rep ID number	Date

Settlement agreement and release

As set forth in this agreement, the claimant, for and in consideration of the receipt of the settlement amount stated herein, approved by the administrator of the Bureau of Workers' Compensation (BWC) and to be paid from the appropriate fund on behalf of the employer, does hereby for him/herself and for anyone claiming by, through, or under him/her, forever release and discharge the above referenced employer, its officers, employees, agents, representatives, successors and assigns, the Industrial Commission of Ohio (IC), the BWC, the appropriate fund, and all persons, firms or corporations from any and all claims, demands, actions, or causes of action incurred on or prior to the date of the approval of this agreement, arising out of Ohio Revised Code Chapter 4121. or 4123., which he/she now has, or which he/she hereafter claims to have, whether known or unknown by reason of or in any manner growing out of the claims or parts thereof set forth above. The afore stated settlement agreement and release shall not be effective if, within thirty days of approval of the settlement agreement by the BWC administrator, any party submits written notification to the other parties of withdrawal from the settlement agreement or the IC disapproves the settlement agreement.

The claimant further understands and agrees that any amount paid pursuant to this agreement is subject to any valid court-ordered child support. The persons involved with filing this settlement agree that if any claim(s) or part of any claim(s) being settled has been recognized or allowed, the cost of all medical services, hospital bills, drugs and medicines with date(s) of service or filling of related prescriptions (not to exceed a 30-day supply) provided to the claimant before the effective settlement date, shall be the responsibility of the state insurance fund, provided such costs result from the allowed conditions of the claims and are properly payable under current medical payment guidelines. Unless this agreement settles indemnity benefits only, the costs of medical services, hospital bills, drugs and medicines provided to the claimant on or after the effective date of the settlement is the responsibility of the claimant.

Additionally, the claimant understands that Medicare does not pay medical bills for conditions covered by claimant's workers' compensation claim and that, if a settlement of a workers' compensation claim is reached, and the settlement allocates certain amounts for future medical expenses, Medicare does not pay for those services until medical expenses related to claimant's workers' compensation claim equal the amount of the settlement agreement allocated to future medical expenses.

Settlement of the claim(s) included in this agreement in no way impairs BWC's statutory rights to subrogation recovery. Further, upon a finding of fraud, the BWC administrator retains the right to rescind this settlement agreement and re-open the included claim(s) for an administrative overpayment hearing and referral for criminal prosecution.

☐ By initialing this box, the claimant acknowledges he/she has read, understands, and agrees to the above statements.

Claimant/Claimant representative signature

I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Claimant signature	Date
Claimant attorney signature	Date

Authorization to receive payment

I hereby authorize and direct BWC to mail directly to my attorney the settlement compensation payment.
This authorization does not give my attorney the authority to cash or endorse a check on my behalf.
This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there is a subsequent hearing, appeal or reconsideration after payment was made.
This authorization is not valid if it is filed beyond 18 months from the date of my signature.

Claimant signature	Date