



## Instructions

- You must file this form when requesting a settlement. In addition:
  - If you are an injured worker receiving permanent total disability (PTD) benefits, an injured worker who is requesting consideration for PTD benefits, or a claimant currently receiving death benefits, you must complete and submit with this settlement application:
    - [Medical History and Disclosure \(C-242\)](#) with supporting medical documentation and; If applying for full settlement the:
    - [PTD-Death Settlement Acknowledgment and Waiver \(C-243\)](#) or;
    - [Indemnity Only Settlement Acknowledgment and Waiver \(C-245\)](#).
  - If you are an injured worker applying for an indemnity only settlement, you must complete and submit with this settlement application:
    - [Indemnity Only Settlement Acknowledgment and Waiver \(C-245\)](#).
- **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 claimant 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 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 mail to BWC Mail Processing Center, Attn: Claims, 30 W. Spring St. Columbus, OH 43215.



Claimant information			
Claimant name		Date of birth	
Address	City	State	ZIP code
Email address		Phone number <input type="checkbox"/> Home <input type="checkbox"/> Cell	

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

Employer of record information			
Employer name	BWC policy 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
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement	
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement	
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement	
	<input type="checkbox"/> Full settlement <input type="checkbox"/> 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.

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

**Employment**  
 Are you still an employee of the employer listed above (the injury employer)?  Yes  No  
 Are you currently working?  Yes  No  
 If yes, name of the employer: \_\_\_\_\_  
 What is your present wage? Per hour: \_\_\_\_\_ Per week: \_\_\_\_\_  
 If no, are you retired?  Yes  No

**Medical treatment**  
 Are you receiving medical treatment at this time for any 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 1-800-999-1118.

**Employer signature exception**

**The employer's signature is not required if:**

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

**Employer/attorney signature**

**Instructions to the employer**

Check the appropriate boxes and sign below.

Pursuant to ORC 4123.65(A) and (G) an employer may not deny or withdraw consent to this settlement application if the claim(s) at issue is/are no longer within the date of experience impact under ORC 4123.34(B), and the claimant is no longer working for the employer. Please check the following boxes.

- The claim(s) listed on this application is/are no longer within my experience impact period.
- This claimant is no longer my employee.

If you have checked both boxes above, it is not necessary to fill out the remainder of this form and you may proceed to sign below.

**Instructions to the employer**

If you have not checked both boxes above, please check one of the following boxes and sign page four. 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. I am supportive of and agreeable to a settlement up to the amount listed on this application.
- B. I do not agree with the requested settlement terms but will participate with BWC in the negotiation process.
- C. I am supportive of and agreeable to settlement of the claims listed on this application. However, I will not participate in the settlement negotiations and request BWC to negotiate the settlement on my behalf.
- D. I am not agreeable to settlement of the claim(s) listed on 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 liability. By signing this agreement, the self-insuring employer acknowledges its obligation to reimburse BWC for the portion of the settlement amount allocated to Disabled Workers' Relief Fund costs of the claims referenced on this application. BWC will bill the Disabled Workers' Relief Fund 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 Disabled Workers' Relief Fund benefits.

Employer signature		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, Ohio Industrial Commission (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 30 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.**

As part of any request to settle where value is placed in future permanent total disability, death benefits, or where the value of a future benefit is affected by the claimant's life expectancy, BWC may require the claimant and/or their representatives to submit additional information. Claimants and/or their representatives have a continuing obligation to promptly update and supplement BWC's request(s) for information. If the claimant or their representative learns the information is materially incomplete or if new information becomes available during negotiation and processing of the settlement, there is a continuing obligation to disclose same with BWC.



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.

All past, present, and future costs and expenses for prosthetics in the included claim(s) are included as part of this settlement.

Are you incarcerated, or are you currently charged with a criminal violation of any federal, state or local statute?

Yes  No

The obligation to inform and/or update BWC is continuing, and applies even if you are released on bail, or under indictment. I agree to update BWC as additional information regarding any criminal matters becomes available.

I have reviewed the answers to the Settlement Agreement and Application for Approval of Settlement Agreement. I agree to update BWC as additional information regarding any criminal matters becomes available. I understand that:

- Inaccurate and/or incomplete information may result in the dismissal or disapproval of my settlement application.
- Inaccurate and/or incomplete information may cause BWC to seek recovery of any settlement funds that are paid out.

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 (required)	Date
Claimant representative signature (required)	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
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