Bureau of Workers' Compensation

State Fund Employer's Agreement to Accept Claim Assignment

Instructions

- Complete this form when you are accepting assignment of a claim that BWC or another party erroneously assigned to another state-fund employer.

Injured worker name	Date of injury	Claim number
Employer name		
Employer policy number	Employer phone number	
Address		
City	State	ZIP code

By signing this form, I acknowledge the following:
I accept reassignment of the above-listed claim to my policy number. I agree to accept responsibility for the above-listed claim and the risk associated with any and all medical benefits and compensation previously paid or to be paid in the claim. I understand that BWC may, upon execution of this agreement, assign the claim to my company and policy number.

Please include comments or exceptions below.

Comments

I certify the information provided is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature
X

Title	Date signed