Bureau of Workers' Compensation

Self-insured Joint Settlement Agreement and Release

Instructions

- Please print or type
- Please file completed application at the nearest regional office of the Industrial Commission of Ohio (IC.)

Injured worker name	Social Security number	Claim number
Employer name		Date of injury/occupational disease

I, _____ and _____ agree to make
(the injured worker) (the employer)

settlement in the amount of $ _____.

1. By agreeing to the above amount, I, the injured worker, forever release and discharge the employer; its officers; employees; agents; representatives; successors and assigns; the IC; BWC; the Ohio State Insurance Fund; and all persons, firms or corporations from any and all self insured claims, demands, actions or causes of action incurred on or before the date of this agreement, which I now have (or I may later claim to have), whether known or unknown, developing out of my employment with this employer or any other employer.

2. The injured worker and employer also agree that if the above claim (or any other claim(s) being settled), were recognized or allowed **prior to the date of this agreement**, then the cost of all medical, pharmacy or hospital bills, nursing services, etc., filed with the employer **is the responsibility of the employer**.

   If such medical costs occurred before the date of this agreement, but not filed with the employer before the date of this agreement, the cost of those services shall be the responsibility of the injured worker. All costs of medical, pharmacy or hospital bills, nursing services, etc., provided to the injured worker **on or after the date of this agreement is also the injured worker's responsibility**.

3. The injured worker and employer agree to exclude the following claim (or claims) from this settlement:

   _____

   _____

4. Additional terms of this settlement agreement are: _____

   _____

The injured worker and employer have signed this final settlement agreement on the date indicated and agree the effective date of this agreement is _____.

This date remains in effect unless denied by the IC within 30 days of the effective date, or the injured worker or employer withdraws this agreement within 30 days of the date of this agreement.

Injured worker signature		Date	Employer signature	Date
Current address			By:	
City	State	Nine-digit ZIP code	State of Ohio - County	

I, _____, state that the injured worker personally appeared before me. The injured worker acknowledges the execution of this agreement for final settlement was made of his/her free will. The injured worker acknowledges this agreement between him/her and the employer will result in a complete and final settlement of all claims listed in this settlement.

In witness thereof, I have set my hand and official seal, this _____ day of _____, 20 ____.

Notary public

I, _____, certify I am the attorney of record for this injured worker. Before signing this settlement agreement, the injured worker either read the agreement or the agreement was read and explained to them. The injured worker stated he or she was satisfied with this settlement.

Attorney of record signature