Bureau of Workers' Compensation

Waiver of Workers' Compensation Benefits for Recreational or Fitness Activities (C-159)

Claim number

Instructions

- Complete this form to waive workers' compensation coverage for voluntary participation in employer-sponsored recreational activities or fitness programs.
- In the space provided, list all employer-sponsored recreational activities and fitness programs for which the employee wishes to waive workers' compensation coverage. Make a line through any blank spaces.
- The employee **must** sign and date this form to acknowledge agreement.
- The employer shall retain the original for their and provide a copy to the employee.
- The employer should submit a copy to BWC **only when an employee files a claim** for an injury or occupational disease sustained in the employer-sponsored recreational activity or fitness program. For further information, call 1-800-644-6292.

Employee name (Please print or type.)	Date
Employer name	Policy number

Pursuant to Section 4123.01(C)(3) of the Ohio Revised Code (ORC), the employer and employee shall list those employer-sponsored recreational activities and fitness programs for which the employee wishes to waive all rights to workers' compensation and benefits. The waiver must be signed and dated prior to the date of injury or, in an occupational disease claim, the date of disability. Should an employee sustain an injury or occupational disease in an employer-sponsored recreational activity or fitness program, **which is not listed**, the employee may be eligible for workers' compensation benefits.

Recreational activities/Fitness programs

I am voluntarily participating in the employer-sponsored recreational activities or fitness programs listed above. I waive my rights to workers' compensation benefits under Chapter 4123 of the ORC for any injury or disability that may occur while I participate in any of the above activities or programs. This waiver is valid for two years. This waiver does not apply to any workers' compensation claim filed for death benefits by my dependents.

Employee signature	Date signed