



Under the Ohio Revised Code Section 4123.343, BWC uses this application to determine the percentage of compensation to properly charge to the Statutory Surplus Fund due to additional claim costs one or more of the existing conditions below:

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| 01 Epilepsy | 11 Cerebral vascular accident | 21 Thrombo-phlebitis |
| 02 Diabetes | 12 Tuberculosis | 22 Varicose veins |
| 03 Cardiac disease | 13 Silicosis | 23 Cardiovascular and pulmonary disease of a firefighter employed by municipal corporation or township as a regular member of a lawfully constituted fire department |
| 04 Arthritis | 14 Psycho-neurotic disability following treatment in a recognized medical or mental institution | 24 Coal miners pneumoconiosis |
| 05 Amputated foot, leg, arm or hand | 15 Hemophilia | 25 Disability with respect to which an individual has completed a rehabilitation program for a previous injury or claim (ORC 4121.61-69) |
| 06 Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75 percent | 16 Chronic osteomyelitis | 26 Service connected injury |
| 07 Residual disability from poliomyelitis | 17 Ankylosis of the joints | |
| 08 Cerebral palsy | 18 Hyper Insulinism | |
| 09 Multiple sclerosis | 19 Muscular dystrophies | |
| 10 Parkinson's Disease | 20 Arterio-sclerosis | |

Attachments:

- Medical evidence (in the form of doctor's reports, diagnostic tests such as an MRI, X-Ray, CT Scan, laboratory records) that the employee suffered from one or more of the conditions listed above.
- Evidence that the condition qualifies for reimbursement under the law, including but not limited to evidence that prior to the injury, disease or death, the disability caused the employee to be hospitalized or to obtain extensive medical treatment. Proof that this caused an increase in claim costs.
- Evidence that the injury, disease, death, or the disability caused the employee to be absent from work for at least eight or more consecutive days or resulted in a scheduled loss under R.C. 4123.57(B).
- Evidence in the form of affidavits or medical reports to support the contention that the injury, disease or death would not have occurred but for the pre-existing disability of the employee or that the resulting disability or death was caused, in part, through aggravation of the disability.
- Under BWC rules, if the application is not accompanied by all relevant medical evidence and substantial proof, the Administrator may dismiss the application.

To be completed by employer or employer representative

Injured worker name	Social Security number	Claim number
Nature of disability	Date of injury	Date of death

Attach evidence demonstrating how the pre-existing disability increased the cost of this claim.

Type of Compensation Temporary Total Wages in lieu of TT (attach proof) R.C. 4123.57 (B) (scheduled loss) Permanent Total Death

Do you request an informal Conference? In person By phone

Fill out information below completely

Employer name		Risk number	
Address		Telephone number	
City	State	Nine-digit ZIP code	Email address
Employer representative name		Docketing (contact name)	
Address		Telephone number	
City	State	Nine-digit ZIP code	Email address
Signature		Date of signature	