Ohio | Bureau of Workers' Compensation

Application for Living Maintenance Wage Loss

Instructions

- You must complete and sign this application when requesting periods of living maintenance wage loss compensation.
- If your employer at the time of injury was self-insuring, send the form to your employer. If not, fax to 1-866-336-8352, send to the customer service office where your claim is assigned.

To be completed by the injured worker			
Injured worker name	Claim number		Date of injury / /
Address	City	State	Nine-digit ZIP code
Current employer		Job title	
Employer address	City	State	Nine-digit ZIP code
Receives a gross weekly salary of	Works Hours per week		

Conditions regarding the receipt of living maintenance wage loss (LMWL)

- I must have a release from my physician to return to work with restrictions at the time of my initial request. To continue to receive LMWL, if I have temporary restrictions, I must also submit restrictions from my physician every six months or when current restrictions expire (whichever comes first). If I have permanent restrictions, I must submit restrictions when BWC requests them.
- I must report all income I receive for all work I perform while receiving LMWL. I must submit, at least on a monthly basis, a copy of all my pay stubs or payroll reports from all my employers, or a *Report of Earnings for Living Maintenance Wage Loss Compensation* (RH-94A) signed by me. Failure to accurately report all my income could result in receiving LMWL to which I am not entitled. This could result in an overpayment and a potential finding of fraud.
- If I have a job that has a substantial variation in income such as commission or self-employment, I must submit, at least quarterly (every 13 weeks), proof of earnings in the form of pay stubs, payroll reports from my employer, or a *Report of Earnings for Living Maintenance Wage Loss Compensation* (RH-94A). If I am self-employed, I understand that present earnings mean my gross income minus business-related expenses.
- If I plan to make a change in employment while receiving LMWL, I must first notify the disability management coordinator assigned to my claim to ensure I remain eligible for LMWL benefits. I will need to provide the job title, expected salary, and scheduled hours of the new employment. I cannot continue to receive LMWL if I choose to work at a lower paying job for reasons unrelated to my allowed injury.

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

Injured worker certification	
By signing below, I certify that I have read and understand the statements above and agree with these conditions.	
Injured worker signature	Date / /