

DWRF Annual Process Letter

(Project Use Only - Corr134)

BWC Logo

mm/dd/yy

Addressed to:
(Injured Worker)

Injured Worker:

Claim Number:

Injury Date:

Claim Type:

Employer's Name:

Policy Number:

Employer Status:

Dear (IW name):

The Ohio Bureau of Workers' Compensation (BWC) has completed our annual review of your file to see if you're eligible to receive benefits from the Disabled Workers' Relief Fund (DWRF). This fund provides supplemental benefits to permanently and totally disabled workers whose workers' compensation benefits haven't kept up with the cost of living.

To determine eligibility, we look to see that your total benefit is per week. If that amount is more than <\$XXX.XX>, you are not entitled to receive additional benefits. However, if your total weekly benefit amount is less than <\$XXX.XX>, you are eligible.

If you receive Social Security disability benefits, we have combined your Social Security benefit rate with your permanent total disability (PTD) rate to determine your DWRF eligibility. If you don't receive Social Security disability benefits, your eligibility is determined by using your PTD benefits only.

In our review we found that <you are entitled to receive an increase in> or <you will receive a decrease in> or <you are no longer entitled to receive> or <you are now entitled to receive> DWRF benefits.

You'll first see this change on the payment issued <first payment issued in new year date>. However, this payment will include only <number of days> of <next year> paid at the new rate. So, your payment will cover <number of days> days at your <current year> rate and two days at your <next year> rate.

<<first payment issued in new year date> payment for DWRF benefits: \$abc.de.

Your <next payment issued in new year date> payment will include two full weeks at your <next year> rate.

<next payment issued in new year date> payment for DWRF benefits: \$fgh.ij.

Since your employer is self-insured, you will continue to receive your PTD benefits from your employer. Your PTD benefits have not changed.>

Or

< <first payment issued in new year date> payment
Permanent total biweekly rate: \$abc.de
DWRf biweekly rate: \$fgh.ij
Total payment amount: \$klm.no

Your <next payment issued in new year date> payment will include two full weeks at your <next year> rate.

<next payment issued in new year date> payment
Permanent total biweekly rate: \$abc.de
DWRf biweekly rate: \$fgh.ij
Total payment amount: \$uvwx.yz

Please note that this is not a change to your permanent total workers' compensation payment. If you have any deductions, such as family support, taken from your PTD, they are not shown in this order, but they will continue to be deducted.>

According to the law, you and your employer have the right to appeal this order. If you or your employer disagree with this decision, either of you may file an appeal within 14 days of receiving this order. Appeals should be filed at the Industrial Commission office listed below:

<IC Office Name>
<IC Office Address>

IF THE IC DOES NOT RECEIVE AN APPEAL WITHIN 14 DAYS, THIS DECISION IS FINAL. However, a telephone call or other correspondence does not alter the need for you to file an appeal if you disagree with this order.

If you have any questions regarding your DWRf benefits, please call 1-800-OHIOBWC press 0 and ask for the DWRf department.

<<DWRf CSS Name>>
<<Service Office>> Team Number: <<Team Number>>
<<S.O. Street Address>> Phone Number: <<Phone>>
<<S.O. City, State, Zip>> Fax Number: <<Fax Number>>

CC: IW Rep
Employer
Employer Rep

