Ohio | Bureau of Workers' Compensation

Settlement Agreement and Application for Approval of Settlement Agreement

(For state-fund claims only)
(Self-insured claims file SI-42)

File this application to settle workers' compensation claims with state-fund employers. Ohio Revised Code 4123.65 requires the injured worker and the employer to sign settlement applications unless the employer is no longer doing business in Ohio. If the claim to be settled is a state-fund claim, and the employer is now self-insuring, BWC charges the self-insuring employer dollar for dollar for any portion of the settlement attributed to past, present or future Disabled Workers' Relief Fund (DWRF) liability.

By filing this application, the injured worker and the employer agree all unresolved issues will be suspended. All ongoing compensation and medical payments, however, will continue until the effective settlement date. The effective settlement date is the mailing date of BWC's approval of settlement agreement.

Please Note: The persons involved with filing this settlement agree if any other claim(s) or part of any claim(s) being settled has been recognized or allowed, then the cost of all medical services, hospital bills, drugs and medicines with date(s) of service or filling of related prescriptions (not to exceed a 30-day supply) provided to the injured worker before the effective settlement date, shall be the responsibility of the state insurance fund, provided such costs result from the allowed conditions of the claims and are properly payable under current medical payment guidelines. The costs of all medical services, hospital bills, drugs and medicine with the date(s) of service of filling of related prescriptions (not to exceed a 30-day supply) provided to the injured worker on or after the effective settlement date are the responsibility of the injured worker.

☐ By initialing this box, the injured worker acknowledges he or she has read and understands the above statement.

Special Notice to Medicare Beneficiaries

Medicare does not pay medical bills for conditions covered by your workers' compensation claim. If a settlement of your workers' compensation claim is reached, and the settlement allocates certain amounts for future medical expenses, Medicare does not pay for those services until medical expenses related to your workers' compensation claim equal the amount of the lump sum settlement allocated to future medical expenses. For additional information, please call the Medicare coordination of benefits contractor at (800) 999-1118.

Instructions

- For lost-time and medical-only claims, mail this completed application to your nearest customer service office.
- Call **1-800-OHIOBWC** for the address of your local customer service office.
- To settle a claim with a self-insuring employer, please complete and forward form SI-42, or contact your self-insuring employer for other forms setting out the agreement between the injured worker and self-insuring employer.
- To facilitate settlement of this claim, please forward any unpaid bills to your managed care organization.
- Include a list of any unpaid bills you are aware of or attach copies of any unpaid bills or statements.

Application for Approval of Settlement Agreement

The injured worker and employer, as agreed to below, make application to BWC for approval of a final settlement in the injured worker's claim(s).

Parties to the Claim

Injured worker name	**Social Security number**	**Date of birth**	**Phone number** ( )
Address	**City**	**State**	**ZIP code**
Injured worker representative name		**ID number**	**Phone number** ( )
Address	**City**	**State**	**ZIP code**
Employer name	**Risk number**	**Fax number** ( )	**Phone number** ( )
Address	**City**	**State**	**ZIP code**
Employer representative name		**Fax number** ( )	**Phone number** ( )
Address	**City**	**State**	**ZIP code**

Information on other relevant employers is attached ☐ **Yes** ☐ **No**

Claim(s) to be Included In Settlement

Claim Number*	Requested amount for complete settlement**	Proposed allocation of requested settlement amount		
		Indemnity	Prescription drugs	Medical

*List any claims specifically excluded from settlement: _____

**Please explain any request for a partial settlement: _____

Clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable.

_____

Has information on other relevant claims been attached? ☐ **Yes** ☐ **No**	**Are you receiving, or have you applied for Medicare benefits?** ☐ **Yes** ☐ **No**	
Are you receiving medical treatment at this time? ☐ **Yes** ☐ **No**	**Who is your treating physician(s)?**	**Wages at time of injury?**
Are you currently working? ☐ **Yes** ☐ **No**	**If yes, who is your present employer?**	**What is your present occupation?**	**What are your present wages?**

Employer Signature
(Required by ORC 4123.65 unless the employer is no longer doing business in Ohio)

Instructions
- Please check one of the following boxes and sign below. Your signature does not waive the employer's right to withdraw consent to the settlement by providing written notice to the employee and the BWC administrator within 30 days after the administrator issues the approval of the settlement agreement.

☐ A. The employer is supportive of and agreeable to a settlement up to the amount listed on the front of this application.

☐ B. The employer does not agree with the requested settlement terms but will participate with the BWC in the negotiation process.

☐ C. The employer is supportive of and agreeable to settlement of the claims listed on the front of this application. However, the employer will not participate in the settlement negotiations and requests the BWC to negotiate the settlement on behalf of the employer.

☐ D. The employer is not agreeable to settlement of the claim(s) listed on the front of this application.

By signing this agreement, an employer that is currently self-insured acknowledges its obligation to reimburse BWC for the portion of the settlement amount allocated to DWRF costs of the above-referenced claim(s). BWC will bill the DWRF portion of the settlement to the self-insuring employer, even if the injured worker has not yet been determined to be permanently and totally disabled or currently eligible for DWRF benefits.

Employer signature	**Title**	**Date**
Telephone number ( )	**Fax number** ( )	

Settlement Agreement and Release

As set forth in this agreement, the injured worker for and in consideration of the receipt of the settlement amount approved by the BWC, which sum will be paid from the appropriate fund on behalf of the employer after approval by the BWC administrator, unless within 30 days after such approval the administrator, the employer or the injured worker, withdraws consent to, or unless the Industrial Commission of Ohio (IC) disapproves the agreement, does hereby for him/herself and for anyone claiming by, through or under him/her, forever release and discharge the above referenced employer, its officers, employees, agents, representatives, successors and assigns, the IC, the BWC, the appropriate fund, and all persons, firms or corporations from any or all claims, demands, actions or causes of action incurred on or prior to the date of the approval of this agreement, arising out of Ohio Revised Code Chapter 4121. or 4123., which he/she now has or which he/she hereafter claim to have, whether known or unknown by reason of or in any manner growing out of the claims or parts thereof set forth above. The injured worker further understands and agrees that any amount paid pursuant to this agreement is subject to any valid court-ordered child support. The persons involved with filing this settlement agree that if any claim(s) or part of any claim(s) being settled has been recognized or allowed, then the cost of all medical services, hospital bills, drugs and medicines with date(s) of service or filling of related prescriptions (not to exceed a 30-day supply) provided to the injured worker before the effective settlement date, shall be the responsibility of the state insurance fund, provided such costs result from the allowed conditions of the claims and are properly payable under current medical payment guidelines. The costs of medical services hospital bills, drugs and medicines (not to exceed a 30-day supply) provided to the injured worker on or after the effective date of the settlement date are the responsibility of the injured worker.

☐ By initialing this box, the injured worker acknowledges he or she has read and understands the above statement.

Also as set forth above, the injured worker understands that any settlement amounts allocated for future medical services must be used for medical services before Medicare will consider payment for services for the conditions of the workers' compensation claim.

Settlement of any claim(s) included in this agreement in no way impairs BWC's statutory rights to subrogation recovery. Also, be advised that upon a finding of fraud, the administrator retains the right to rescind this settlement agreement and re-open the claim for an administrative overpayment hearing and referral for criminal prosecution.

Injured worker signature	**Date**

Power of Attorney

By signing below the injured worker grants a limited power of attorney to the attorney of record for the purpose of receiving the warrant issued because of this settlement agreement.

Injured worker signature	**Date**
Representative signature	**Date**