



Under the Ohio Revised Code Section 4123.343, BWC uses this application to determine the percentage of compensation to properly charge to, or to refund from, the Statutory Surplus Fund due to an aggravation of one or more of the pre-existing conditions below:

Table listing 26 pre-existing conditions such as Epilepsy, Diabetes, Cardiac disease, Arthritis, Amputated foot, etc.

Attachments

- 1. Medical evidence (in the form of doctor's reports, diagnostic tests such as an MRI, X-RAY, or CTScan, laboratory records) that the employee suffered from one or more of the conditions listed above.
2. Evidence that the condition constituted a handicap within the meaning of the law, including but not limited to evidence that prior to the injury, disease or death, the handicap condition caused the employee to be hospitalized or to obtain extensive medical treatment.
3. Evidence that the injury, disease, death, or the handicap condition 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).
4. 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 handicap condition of the employee or that the resulting disability or death was caused, in part, through aggravation of the handicapped condition.
5. Under BWC rules, if the application is not accompanied by all relevant medical evidence and substantial proof, the Administrator may dismiss the application.

Filing instructions

- You may hand deliver or mail this application to: BWC, Attn: Handicap Reimbursement Unit, 30 West Spring St. 26th floor, Columbus, OH 43215-2256
If you provide a copy of the application and a self-addressed stamped envelope, BWC will mail a date stamped copy to the employer representative. Note: You may e-mail any questions concerning the Handicap Reimbursement Program by using: HandreimbQuest@bwc.state.oh.us

To be completed by employer or employer representative. Form fields include: Injured worker name, Social Security number, Claim number, Nature of handicap, Date of injury, Date of death, History of injury, Allowed condition(s) in this claim, State how the pre-existing handicap increased the cost of this claim, Type of compensation, Do you request an informal conference, Contact name.

Fill out information below completely. Form fields include: Employer name, Risk number, Manual number, Address, Telephone number, City, State, Nine-digit ZIP code, E-mail address, Employer representative name, Docketing (contact name).