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|---------------------|---------------|------|
| Injured worker name | Employer name | Date |
|---------------------|---------------|------|

As amended below, the injured worker and the employer have agreed to the terms in the *Application for Approval of Settlement Agreement*, which the injured worker signed on _____, and filed with the BWC.

The settlement amount shall be \$ _____

The settlement **shall include** the claim number(s) listed and be allocated as follows:

| Claim number(s) | Indemnity | Prescription drugs | Medical | Total |
|-----------------|-----------|--------------------|---------|----------|
| _____ | _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | _____ | \$ _____ |
| _____ | _____ | _____ | _____ | \$ _____ |

The settlement **shall exclude** claim number(s) _____

Other _____

Please complete Settlement Agreement and Release section, below. Employer signature is required below, unless the amended settlement is less than the amount the employer previously approved in writing.

| Employer Information | | |
|----------------------|-------|------|
| Employer signature | Title | Date |

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 further 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 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.

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 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 pursuant to the amended settlement terms.

| | |
|--------------------------|------|
| Injured worker signature | Date |
|--------------------------|------|

| | | |
|--------------------------|----------------------------|------|
| Representative signature | Representative I.D. number | Date |
|--------------------------|----------------------------|------|

DISTRIBUTION: 1 copy each to: Injured worker - Employer - Injured worker's representative - Employer's representative - Claim file