

# **BWC Lump Sum Settlements**

Richard Blake, Jeff Travis & Jay Hurlbert

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# Notice of Intent to Settle Pursuant to R.C. 4123.512

## Extension of Intent to Settle to all Claims

- The “Intent to Settle” provision of R.C. 4123.512 has been made retroactive and extends to all claims. Previously under H.B. 27 only claims occurring on or after September 29, 2017, were eligible. Customers may now submit a C-512 application for any claim, regardless of date, and it will be processed in our normal manner.

# Notice of Intent to Settle C-512

Ohio Revised Code (ORC) 4123.512 provides: “The filing of the notice of intent to settle extends the time to file an appeal to 150 days, unless the opposing party files an objection to the notice of intent to settle within 14 days after the date of the receipt of the notice of intent to settle. Either the claimant or the employer may file a notice of an intent to settle the claim within 30 days after the date of the receipt of the order appealed from or of the order of the commission refusing to hear an appeal of a staff hearing officer's decision. The claimant or employer shall file notice of intent to settle with the administrator of workers' compensation, and the notice shall be served on the opposing party and the party's representative. The filing of the notice of intent to settle extends the time to file an appeal to 150 days, unless the opposing party files an objection to the notice of intent to settle within 14 days after the date of the receipt of the notice of intent to settle.”

# Notice of Intent to Settle C-512

- **Instructions to the filing party**
  - You must file this form to begin the settlement process if you are attempting to use the provisions of ORC 4123.512 to settle rather than appeal the order into court.
  - You must also serve a copy of this form on the opposing party, the party's attorney, and BWC.
- **You must fax this form to 614-621-3395.**

# Notice of Intent to Settle C-512

- **Instructions to the opposing party**
  - Please indicate whether you agree with going forward with the settlement process or whether you object to extending the time to file an appeal into court under ORC 4123.512.
  - If you object to this notice, you must also serve a copy within 14 days of your receipt of this notice on the party that filed this form, the party's attorney, and BWC.
- **You must fax this form to 614-621-3395 within 14 days of receipt.**

## Notice of Intent to Settle (C-512)

Claim number
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Note: Ohio Revised Code (ORC) 4123.512 provides: "The filing of the notice of intent to settle extends the time to file an appeal to 150 days, unless the opposing party files an objection to the notice of intent to settle within 14 days after the date of the receipt of the notice of intent to settle. Either the claimant or the employer may file a notice of an intent to settle the claim within 30 days after the date of the receipt of the order appealed from or of the order of the commission refusing to hear an appeal of a staff hearing officer's decision. The claimant or employer shall file notice of intent to settle with the administrator of workers' compensation, and the notice shall be served on the opposing party and the party's representative. The filing of the notice of intent to settle extends the time to file an appeal to 150 days, unless the opposing party files an objection to the notice of intent to settle within 14 days after the date of the receipt of the notice of intent to settle."

**Instructions to the filing party**

- You must file this form to begin the settlement process if you are attempting to use the provisions of ORC 4123.512 to settle rather than appeal the order into court.
- You must also serve a copy of this form on the opposing party, the party's attorney, and BWC.
- You must fax this form to 614-621-3395.

**Instructions to the opposing party**

- Please indicate whether you agree with going forward with the settlement process or whether you object to extending the time to file an appeal into court under ORC 4123.512.
- If you object to this notice, you must also serve a copy within 14 days of your receipt of this notice on the party that filed this form, the party's attorney, and BWC.
- You must fax this form to 614-621-3395 within 14 days of receipt.

Claimant information				
Name			Date of injury	
Address				Phone number
City	State	ZIP code	Email address	
Claimant attorney information				
Name			Rep ID number	
Email Address			Phone number	
Employer information				
Name			Policy number	
Address				Phone number
City	State	ZIP code	Email address	
Employer attorney information				
Name			Rep ID number	
Email Address			Phone number	



## Notice of Intent to Settle (C-512)

Claim number

<b>Party filing the notice of intent to settle</b>	
You are which of the following (check one) <input type="checkbox"/> Claimant <input type="checkbox"/> Employer	
Date the Ohio Industrial Commission order was received	Settlement demand
Provide the date(s) you served copies to the following	
Opposing party	If applicable, <b>opposing party's</b> attorney
Date	Date
<b>Filing party's signature</b>	
I have provided accurate and complete information. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC, or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution. Under appropriate criminal provisions, he or she may be punished by a fine, imprisonment or both.	
By signing below, I acknowledge I am requesting to initiate the administrative settlement process and extend the time to file an appeal into court. I also certify that I served copies of <b>this notice on the opposing party and opposing party's attorney</b> , as indicated above.	
<b>Applicant's signature</b>	Date
<b>Applicant's attorney signature</b>	Date
<b>Opposing party's response to intent to settle</b>	
<input type="checkbox"/> I am supportive of initiating the settlement process	
<input type="checkbox"/> I object to the request to initiate the settlement process	
Provide the date(s) you served copies of your response to the following	
Filing party	If applicable, <b>filing party's</b> attorney
Date	Date
<b>Opposing party's signature</b>	
I have provided accurate and complete information. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution. Under appropriate criminal provisions, he or she may be punished by a fine, imprisonment or both.	
By signing below, I acknowledge my position regarding the <b>filing party's request to initiate the administrative settlement process</b> and extend the time to file an appeal into court. I also certify that I served copies to the filing party and <b>filing party's attorney</b> , as indicated above.	
<b>Opposing party's signature</b>	Date
<b>Opposing party's attorney signature</b>	Date

# Employer Objection

- R.C. 4123.65 is revised to bar an employer's objection to a settlement where the claim at issue is outside of the employer's experience and the claimant no longer works for the employer. This change applies retroactively to all claims and to all employers. For example:
  - For state funded employers, the final date of impact will be the final survey date;
  - For employers participating in the deductible program a claim will have impact until the deductible is met;
  - For individually retrospectively rated employers the final date of impact will be the ten-year closeout date;
  - For public employer tax districts, the final date of impact will be the final survey date.
  - Claims with employers who are state agencies and claims with self-insuring employers will always be considered in experience for the purpose of R.C. 4123.65 and a signature will be required to perfect an administrative settlement.

Claimant Information			
Claimant name		Date of birth	
Address	City	State	ZIP code
Email address		Phone number <input type="checkbox"/> Home <input type="checkbox"/> Cell	
<b>If you are the injured worker, you are required to answer the following questions.</b>			
<b>Employment</b>			
Are you still an employee of the employer listed below (the injury employer)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, name of the employer: _____			
What is your present wage? Per hour: _____ Per week: _____			
If no, are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Medical treatment</b>			
Are you receiving medical treatment at this time for any claims listed below? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Claimant representative information			
Claimant representative name		Fax number	Phone number
Email address		Representative ID number	
Employer of record information			
Employer name		Real number	Phone number
Email address		Fax number	Phone number
Email address			
Employer representative information			
Employer representative name		Fax number	Phone number
Email address		Representative ID number	
All claims for which the claimant and above named employer make application to BWBC for approval of settlement:			
Claim number	Please select type of settlement being requested (select only full or partial).	Requested settlement amount	
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement		
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement		
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement		
	<input type="checkbox"/> Full settlement <input type="checkbox"/> Indemnity only settlement		
Clearly set forth the circumstances by reason of which the proposed settlement is deemed desirable, describe briefly why you want to settle your claim(s). This information is REQUIRED pursuant to Ohio Revised Code (ORC) 4123.06.			

Special notice to Medicare beneficiaries		
Are you receiving, or have you applied for Medicare benefits, or filed an appeal on a denied application? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, 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 800-698-1118.		
Employer/attorney signature or settlement acknowledgment of exception		
<b>Instructions to the employer</b>		
Check the appropriate boxes and sign below.		
Pursuant to ORC 4123.05(A) and (B) an employer may not deny or withdraw consent to this settlement application if the claim(s) at issue is/are no longer within the date of experience impact under ORC 4123.34(B), and the claimant is no longer working for the employer. Please check the following boxes.		
<input type="checkbox"/> The claim(s) listed on the front of this application is/are no longer within the date of the employer's experience impact.		
<input type="checkbox"/> This claimant no longer works for the employer.		
If the employer has checked both of the boxes above, it is not necessary to fill out the remainder of this form and the employer may proceed to sign below.		
<ul style="list-style-type: none"> <li>• The claim(s) involved in the settlement application is/are out of the employer's experience, and the claimant is no longer employed with the employer.</li> <li>• The employer has failed to pay premiums as required by Section 4123.36 of the ORC.</li> </ul>		
<input type="checkbox"/> Check here if the employer's signature has not been provided due to one of these exceptions.		
<b>Instructions to the employer</b>		
If the employer has not checked both boxes above, please check one of the following boxes and sign below. Your signature does not waive your right as the employer 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.		
<input type="checkbox"/> The employer is supportive of and agreeable to a settlement up to the amount listed on the front of this application.		
<input type="checkbox"/> The employer does not agree with the requested settlement terms but will participate with the BWC in the negotiation process.		
<input type="checkbox"/> 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.		
<input type="checkbox"/> The employer is not agreeable to settlement of the claim(s) listed on the front of this application.		
<b>Settlement of a state-fund claim(s) when the employer is now self-insuring</b>		
If the claim to be settled is a state-fund claim(s), 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 (DWRIF) liability. By signing this agreement, the self-insuring employer acknowledges its obligation to reimburse BWC for the portion of the settlement amount allocated to DWRIF costs of the above-referenced claim(s). BWC will bill the DWRIF portion of the settlement to the self-insuring employer, even if the claimant has not yet been determined to be permanently and totally disabled, or currently eligible for DWRIF benefits.		
Employer signature	Title	Date
Employer attorney signature	Attorney reg ID number	Date

**Settlement agreement and release**

As set forth in this agreement, the claimant, for and in consideration of the receipt of the settlement amount stated herein, approved by the administrator of the Bureau of Workers' Compensation (BWC) and to be paid from the appropriate fund on behalf of the employer, does hereby for himself 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, Ohio Industrial Commission (IC), the BWC, the appropriate fund, and all persons, firms or corporations from any and 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 holds him/her, or which he/she heretofore claims 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 above stated settlement agreement and release shall not be effective if, within 30 days of approval of the settlement agreement by the BWC administrator, any party submits written notification to the other parties of withdrawal from the settlement agreement or the IC disapproves the settlement agreement.

The claimant 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, 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 claimant 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. Unless this agreement settles indemnity benefits only, the costs of medical services, hospital bills, drugs and medicines provided to the claimant on or after the effective date of the settlement is the responsibility of the claimant.

Additionally, the claimant understands that Medicare does not pay medical bills for conditions covered by claimant's workers' compensation claim and that, if a settlement of a 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 claimant's workers' compensation claim equal the amount of the settlement agreement allocated to future medical expenses.

As part of any request to settle where value is placed in future permanent total disability, death benefits, or where the value of a future benefit is affected by the claimant's life expectancy, BWC may require the claimant and/or their representative to submit additional information. Claimants and/or their representatives have a continuing obligation to promptly update and supplement BWC's request(s) for information. If the claimant or their representative learns the information is materially incomplete or if new information becomes available during negotiation and processing of the settlement, there is a continuing obligation to disclose same with the BWC.

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

By initialing this box, the claimant acknowledges he/she has read, understood, and agrees to the above statements.

**Claimant/Claimant representative signature**

I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, both,

Claimant signature	Date
Claimant attorney signature	Date

**Authorization to receive payment**

I hereby authorize and direct BWC to mail directly to my attorney the settlement compensation payment. This authorization does not give my attorney the authority to cash or endorse a check on my behalf. This authorization shall not continue in effect after BWC has paid said award(s) on the original application noted above unless there is a subsequent hearing, appeal, or reconsideration after payment was made. This authorization is not valid if it is filed beyond 18 months from the date of my signature.

Claimant signature	Date
Claimant attorney name	Attorney reg ID number

# Pre-PTD Settlement Evaluations

When evaluating the likelihood that a Claimant will be granted PTD, the settlement team considers the following factors:

- Claim history that impacts the Claimant's ability to return to work
- Medical history and current treatment
- Vocational rehabilitation history
- The filed Application for Compensation for Permanent Total Disability (IC-2)
- Medical reports submitted in association with the PTD Application
- Non-medical PTD factors, including:
  - Education level
  - Work history
  - Literacy skills
  - Other factors such as learning disabilities, languages, skills or special training
- Any other factors that impact the likelihood of the Claimant's returning to work
- Co-morbidities

# Death of a Claimant during the 30-day hold

- If death occurs before approval of the Administrator (BWC order) the claim abates under OAC 4123-5-21(A)
- If death occurs after approval of the Administrator and inside the 30-day hold, the settlement is subject to review under R.C. 4123.65(C) and the Administrator may withdraw for “good cause.”
- If the BWC determines that good cause does not exist to void the settlement, the settlement will be reinstated and paid to the estate of the deceased claimant upon receipt of necessary documentation. Necessary documentation to complete the settlement includes, but is not limited to:

# Death of a Claimant during the 30-day hold

- Probate estate documents from a Probate Court naming an Administrator Executrix or Executor of the claimant's estate
- An updated R-2 and C-230 from the claimant's counsel indicating they represent the estate of the claimant;
- The claimant's death certificate; and
- Medical records surrounding the time of death
- Upon receipt of this information, the settlement team will review and make a determination whether to pay the settlement to the estate
- Here is the link on the BWC website to the BWC policy for the Death of a Claimant during the 30-day waiting period:
- [https://www.bwc.ohio.gov/basics/PolicyLibrary/FileShell.aspx?file=%2fClaims+Policy%2fLump+Sum+Settlement.htm#\\_Toc97537761](https://www.bwc.ohio.gov/basics/PolicyLibrary/FileShell.aspx?file=%2fClaims+Policy%2fLump+Sum+Settlement.htm#_Toc97537761)



# Questions?



**Vision:** To transform BWC into an agile organization driven by customer success.

**Mission:** To deliver consistently excellent experiences for each BWC customer every day.

**Core Values:** One Agency, Personal Connection, Innovative Leadership, Relentless Excellence.

