Ohio | Bureau of Workers' Compensation

Self-Insured Employer's Certification of Assignment After Initial Allowance

Instructions

- Complete this form in its entirety when you are accepting assignment of a claim that BWC or another party erroneously assigned to another self-insured employer.

Injured worker name	Date of injury	Claim number
Employer name		
Employer policy number	Employer phone number	
Address		
City	State	ZIP code

By signing this form, I acknowledge the following:

I understand BWC or another party erroneously assigned the claim to another self-insured employer and, upon execution of this agreement, will assign it to the policy number listed above.

I accept the responsibility to reimburse_____*[employer's name]*

_____*[Address, City, State, ZIP code]*

_____*[policy number]* for all medical benefits and compensation previously paid in this claim to date and to assume responsibility for any and all future claim costs going forward.

Please include comments or exceptions below.

Comments

I certify the information provided is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Signature **X**	
Title	Date signed