



Injured worker's name	Claim number
Attorney's name Melanie Miguel-Courtad	Representative ID number 016823-90

Instructions for completion

- You must complete this form in its entirety, including the correct claim number.
- You must file a separate authorization for each claim and for each application, motion or order.

BWC will not honor an authorization that is not completed in its entirety, is altered but not initialed by the party altering the form or is not timely filed.

Time limits for filing are as follows:

On all types of compensation, other than an application for the percentage of permanent partial compensation (C-92), you must file the authorization to receive workers' compensation payment:

- Prior to or at the hearing;
- Prior to the date of the payment of compensation (before the award is issued) whether the award of compensation was made at a hearing or made without a hearing.

On any compensation paid pursuant to a C-92 application or an agreement of the parties to a percent permanent partial award, you must file the authorization:

- With the application or the agreement for permanent partial disability;
- With the application for the election of permanent partial from temporary partial;
- With the Industrial Commission of Ohio at the hearing;
- After the hearing but prior to the date of mailing of the hearing officer order.

I hereby authorize and direct BWC to mail directly to my attorney the compensation payment in the above numbered claim for the accrued portion of my award as specified below. You must specify the date of the application, request, motion or order.

Application, request, motion or order dated \_\_\_/\_\_\_/\_\_\_ for the type(s) of compensation listed below.

Check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> Temporary total            | <input type="checkbox"/> Impairment of earning capacity |
| <input type="checkbox"/> Wage loss                  | <input type="checkbox"/> Violation of specific safety   |
| <input type="checkbox"/> Change of occupation       | <input type="checkbox"/> Facial disfigurement           |
| <input type="checkbox"/> Scheduled loss             | <input type="checkbox"/> Lump sum settlement            |
| <input type="checkbox"/> Permanent total disability | <input type="checkbox"/> Percentage permanent partial   |
| <input type="checkbox"/> Death benefits             | <input type="checkbox"/> Lump sum advancement           |

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.

Injured worker's/claimant's signature	Date
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