

In the
Supreme Court of Ohio

FRISCH'S RESTAURANTS, INC., et al, : Case No. 2007-0544
: :
Appellants, : On Appeal from the
: Franklin County
v. : Court of Appeals,
: Tenth Appellate District
MARSHA P. RYAN, ADMINISTRATOR, :
OHIO BUREAU OF WORKERS' :
COMPENSATION, :
: :
Appellee. :

**MERIT BRIEF OF
APPELLEE MARSHA P. RYAN, ADMINISTRATOR,
OHIO BUREAU OF WORKERS' COMPENSATION**

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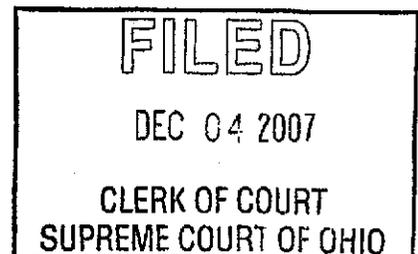


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INTRODUCTION

The issue in this case is whether the Appellee Administrator of the Bureau of Workers' Compensation ("Administrator") reasonably awarded—but only to certain eligible employers—rebates on employers' premiums for workers' compensation coverage. Appellants here—Frisch's Restaurants, Inc. ("Frisch's"), United Dairy Farmers, Inc. ("UDF"), J.W. Harris Co., Inc. ("Harris"), and Peck, Hannaford & Briggs ("PH&B") (collectively "Appellants")—are four employers that the Administrator determined were ineligible to receive rebates because they were no longer participating in the particular workers' compensation programs whose participants received rebates.

Specifically, each of the four Appellants had participated in the Bureau's retrospectively-rated workers' compensation program ("Retro" program) through the State Insurance Fund ("Fund") at one time. Each Appellant here terminated its participation in the Retro program, changing their coverage to another program, but continued to make so-called "look-back" payments for past years, as the Retro program requires. The Administrator issued premium rebates to Fund subscribers, as authorized by former R.C. 4123.32(A) for the premium years 1995 through 2002. The Administrator chose, as part of the rebate program, to give rebates only to premiums paid by current subscribers in Bureau programs, and only for premiums paid under the particular program in which an employer was participating for the rebate year. Because Appellants were not Retro program subscribers for some or all of the rebate years, they did not receive premium rebates for Retro payments, even when they were made during rebate years. Appellants now challenge the Administrator's sensible decision to exclude them, but that challenge should fail.

Appellants' claim to rebates rests solely on the fact that the Retro program requires continued payments even after an employer stops participating in the Retro program, so

understanding the flaw in their argument requires a review of the Retro and other workers' compensation programs. An employer must cover its workers' compensation risk for a given year in one of five ways. An employer may, with the Bureau's permission, be self-insured. Otherwise, it must be covered under one of four plans through the Bureau. The first three—called "base," "experience," and "group,"—involve the relatively straightforward payment of a premium into the Fund in exchange for coverage from the Fund for a given year. The fourth—the "Retro" program—is more complicated, as it involves a small initial premium and then a stream of ten yearly look-back payments and a final adjustment for each covered year. Thus, an employer whose risk for a particular year is covered by the Retro program must continue to pay the "look-back" payments into the future to cover the risk for that year, even if the employer changes to one of the other plans for its coverage of the risk for those future years. Thus, apart from any rebate issues, a Retro program participant who leaves the Retro program will always need to make "look-back" payment in the years after it leaves the program, but these follow-up obligations do not change the fact that it has left the program.

It is in this context—that former Retro program participants always have past-participation obligations—that the rebate issue arose. Under former R.C. 4123.32(A), the Administrator may award rebates for workers' compensation premiums paid by "subscribers to the [F]und," and did so for the years 1995 through 2002. The Administrator properly interpreted "subscribers to the [F]und" to mean only those employers whose risk for a particular year is covered by one of the Bureau programs; that is, those employers who are current participants. In each rebate year, the Administrator awarded rebates only for premiums paid into the single Fund program under which each employer's risk was covered for that rebate year. In other words, in a particular

rebate year, rebates for Retro payments were made only to those employers whose risk was covered under the Retro program for that particular rebate year.

That sensible rule precluded eligibility for all four Appellants, as none were Retro participants in the rebate years. Three of the Appellants—Frisch’s, UDF, and Harris—claim that they are “subscriber[s] to the fund” for the rebate years, but they were self-insured for those years. These self-insured Appellants were making Retro program “look back” payments for past years during the rebate years, even though their risk for the rebate years was not covered by the Fund. The fourth Appellant—PH&B—had transferred to the group rating program, but it too, claims rebates for Retro payments made during years after they had left the Retro program. In sum, all of the Appellants claim they are owed rebates for the Retro payments they made during the rebate years to cover the risk for non-rebate years.

The Administrator’s decision to exclude former Retro participants from rebate eligibility—despite their ongoing post-participation look-back payments—was a legal exercise of his discretion. The term “subscriber” is not defined in the statute or elsewhere, and therefore the Administrator’s reasonable interpretation of the term is owed deference by the courts. The Administrator’s interpretation is reasonable as applied here. Frisch’s, UDF, and Harris paid no premiums whatsoever to cover their risk for the rebate years at issue; the Administrator properly decided not to define them as “subscribers,” even though they might have formerly been subscribers, and even if they made Retro payments during the rebate years for previous years in which they were subscribers. Similarly, PH&B was given a rebate for the premiums paid for coverage of its risk for the rebate year under the group rating program; again, the Administrator properly refused rebates for Retro payments made to cover a non-rebate year.

And finally, the Administrator properly awarded rebates for Retro payments to employers in the Retro program during the rebate year, even though some of those payments cover past, non-rebate years. Retro employers will continue to pay premiums to cover the risk of the rebate year into future years, many of which will not be rebate years. The Administrator rebated payments for past years as a reasonable substitute for rebating future payments for coverage of the risk incurred in a rebate year.

Moreover, any “classification” that results from the Administrator’s issuance of rebates is rationally related to the legitimate government interest of fairly rebating excess premiums in the Fund. Each employer was awarded rebates for only one program at a time—the program for which it paid premiums to cover its risk for the rebate year. Any difference in treatment of rebates is therefore due to the differences between the various insurance programs, not the method of rebate. Therefore, the Court should affirm the grant of summary judgment in the Administrator’s favor.

Alternately, the Court should affirm on the ground that all Appellants here have waived their right to challenge premium rebates. The self-insured Appellants executed buy-out agreements expressly waiving any claims for premium adjustments. And the Fund Appellant, PH&B, as part of a settlement agreement, similarly waived any right to challenge the rebates for the years in question here.

STATEMENT OF THE FACTS AND CASE

- A. Employers may insure workers’ compensation risk through one of five programs; retrospectively rated coverage requires a three-part payment for each year of coverage.**

Employers in Ohio must either insure their workers’ compensation risk through the Workers’ Compensation Fund (“State Fund” or “Fund”) or, with permission of the Bureau of Workers’ Compensation (“Bureau”), be self-insured. For employers who participate in the State

Fund, the Bureau offers employers a variety of options, including: 1) base rated coverage; 2) experience rated coverage; 3) group rated coverage; and 4) retrospectively rated coverage (the “Retro program”). Complaint (“Comp.”) at paragraph (“¶”) 15; Second Supplement (“BWC Supp.”) at 6. Base, experience and group rated employers pay a semi-annual premium for their workers’ compensation coverage, based on one of three methods of calculating claim risk. Comp. at ¶ 16; BWC Supp. at 6. The premiums are calculated to cover the risk for claims of injury, death or occupational disease occurring to employees during the covered year. Phillip Fulton, *Ohio Workers’ Compensation Law*, Second Ed. at § 14.4, citing R.C. 4123.29.

In contrast, employers participating in the Retro program make payments under a more complicated system. The Retro scheme involves a three-part, ten-year stream of payments for each covered year. Part one is a minimum semi-annual premium payment for the covered year that is significantly less than the premiums paid by employers in the other Fund programs. Deposition of Vicky Pickens (“Pickens Dep.”) at 79-80, 94-96; BWC Supp. at 59-60. Part two of the payment is a series of annual adjustments; each year the employer reimburses the Bureau for any amounts the Bureau paid in the previous year for claims filed in the covered year (“look-back” payments). *Id.* The annual adjustment or “look-back” is paid for each of the ten years following the covered year (the “ten-year evaluation period”). The third payment is a final adjustment paid at the end of the ten-year evaluation period. Comp. at ¶ 17; BWC Supp. at 6. The final adjustment covers any claims costs that were paid by the Bureau during the final year of the ten-year evaluation period, and also includes any reserves that are charged to claims filed during the covered year. David Jacobs Dep. at 9-10; BWC Supp. at 52-53. In other words, the employer reimburses all claims paid by the Bureau for claims arising in the covered year, in exchange for greatly reduced initial premiums for the covered year. All three types of Retro

payments, no matter when paid, relate back to claims filed during the covered year; they are not calculated or paid based on claims filed in later years, even if payments were made during those later years.

As an alternative to State Fund coverage, employers may apply to be self-insured. Self-insured employers are approved by the Bureau to obtain their own workers' compensation insurance. Comp. at ¶ 18; BWC Supp. at 6. To be self-insured an employer must be approved as a good risk and the employer must pay a buy-out fee, in the hundreds of thousands to the millions of dollars. Herf Dep. at 61, BWC Supp. at 44. If approved, employers are required to execute a buy-out agreement, in which they affirmatively waive any rights to challenge the Bureau's determinations regarding premium refunds. BWC Supp. at 33. Once an employer becomes self-insured, it, and not the Fund, is responsible for payment of all workers' compensation claims.

Employers may switch from one insurance option to another within the State Fund or to self-insured status, Comp. at ¶ 19; BWC Supp. at 7. However, an employer moving out of the Retro program must continue to pay the annual and final adjustment payments related to each past covered year of participation in the Retro program, even if the employer is no longer a State Fund participant but is self-insured.

B. The Administrator, at his discretion, may return excess surplus to fund subscribers that he deems eligible for such refunds.

When there was a surplus in the State Fund, the Administrator, at the times relevant here, could, in his discretion, return the excess to Fund participants. Specifically, R.C. 4123.32(A), at all times relevant to this case, required the Bureau, with the "advice and consent of the workers' compensation oversight commission," to adopt a:

[r]ule providing that in the event there is developed as of any given rate revision date a surplus of earned premium over all losses which, in the judgment of the

administrator, is larger than is necessary adequately to safeguard the solvency of the fund, the administrator may return such excess surplus *to the subscriber to the fund* in either the form of cash refunds or a reduction of premiums, regardless of when the premium obligations have accrued.

R.C. 4123.32(A) (emphasis added).¹ The Bureau adopted such a rule, Ohio Adm. Code (“OAC”) 4123-17-10, which gave the Administrator discretion to determine, among other things, which employers are eligible for refunds from the fund, and the payroll periods for which refunds apply:

The administrator, with the advice and consent of the workers’ compensation oversight commission, shall have the discretion and authority to determine whether there is an excess surplus of premium; whether to return the excess surplus to employers; the nature of the cash refunds or reduction of premiums; *the employers who are subscribers to the state insurance fund who are eligible for the cash refunds or reduction of premiums*; the payroll period or periods for which a reduction of premium has accrued and the premium payment for which the reduction of premium applies; the applicable date of the cash refunds or reduction of premiums; and any other issues involving cash refunds or reduction of premiums due to an excess surplus of earned premium.

OAC 4123-17-10 (emphasis added). Thus, the Administrator had discretion to determine when premium refunds or reductions are issued, and to whom.

¹ The Administrator no longer has this power. House Bill 100 rescinded subsection (A) of R.C. 4123.32 and gave a similar power and duty to the Workers’ Compensation Board in new R.C. 4123.321. The current R.C. 4123.321 reads:

The bureau of workers’ compensation board of directors, based upon recommendations of the workers’ compensation actuarial committee, shall adopt a rule with respect to the collection, maintenance, and disbursements of the state insurance fund providing that in the event there is developed as of any given rate revision date a surplus of earned premium over all losses that, in the judgment of the board, is larger than is necessary adequately to safeguard the solvency of the fund, the board may return such excess surplus to the subscribers to the fund in either the form of cash refunds or a reduction of premiums, regardless of when the premium obligations have accrued.

Effective Date: 2007 HB100, 09-10-2007.

C. The Administrator determined that refunds were appropriate for the 1995 through 2002 premium years; for purposes of eligibility, employers could actively participate in only one insurance program at a time.

For each of the years 1995 through 2002, the Administrator determined that the State Fund had an excess of surplus premiums sufficient to warrant a refund. He determined that all employers actively participating in the State Fund were subscribers eligible for premium refunds or rebates sometimes referred to as “dividend credits” or “premium rebates.” Martin Herf Dep. at 76-77; BWC Supp. at 47-48.

For purposes of eligibility, the Administrator determined that an employer could actively participate in only one insurance program at a time. Pickens Dep. at 182-183; BWC Supp. at 63; see also, Herf Dep. at 81-82; BWC Supp. at 49-50. Employers who had become self-insured before a given rebate year were no longer covered under the State Fund, and, therefore were no longer paying premiums for coverage under the State Fund. Such employers did not receive any premium rebate. Pickens Dep. at 148-149; BWC Supp. at 61.

In addition, employers who had switched from the Retro program to another State Fund program, or to self-insured status, were not considered to be actively participating in the Retro program if all they were paying during a rebate year were the annual and final adjustment payments for previously covered years. Pickens Dep. at 182-183; BWC Supp. at 63; see also, Herf Dep. at 81-82; BWC Supp. at 49-50. The rebates applied to the initial premium and annual and final adjustment payments, but only those made by employers actively participating in the Retro program during a given rebate year. That is, only employers whose workers’ compensation liability was covered under the Retro program for claims filed in the rebate year could get rebates for all three types of Retro payments made during the rebate year.

In addition, during the years the Bureau declared a surplus, the buy-out fee to convert from one of the Fund programs to self-insured status was waived. The waiver allowed qualified

employers—including some of the Appellants here, as explained below—to switch to self-insured status without paying the otherwise expensive buy-out fee. Herf Dep. at 60-62; BWC Supp. at 43-45.

D. Appellants here were not actively participating in the Retro program during some or all of the rebate years, and were therefore ineligible for rebates of Retro payments; however, some appellants were eligible for, and took advantage of, the waiver of the buy-out fee.

Appellants are four employers that, at one time, participated in the Bureau's Retro program and, accordingly, received their workers' compensation coverage through the State Fund. However, three of the four converted to self-insured status, and thereby became ineligible, under the Administrator's criteria, for premium rebates for the rebate years they were no longer covered under the State Fund. The fourth was group-rated for some of the rebate years, so the Administrator likewise found it ineligible for rebates for its Retro payments made during those years.

Appellant Frisch's participated in the Retro program from July 1, 1992 to May 30, 1996. Comp. ¶ 5; BWC Supp. at 3. The Bureau granted Frisch's request to become self-insured effective June 1, 1996. *Id.* Frisch's signed a 1995 buy-out agreement. BWC Supp. at 34. In it Frisch's waives the right to contest premium or loss adjustments:

"The employer, its assigns and successors in interest expressly waives forever any claims for premium or loss adjustments not expressly contained in this agreement."

BWC Supp. at 34. Because a surplus had been declared for 1995, Frisch's did not have to pay a buy-out fee. This was a significant factor in Frisch's decision to become self-insured, as the fee had been six million dollars, which Frisch's considered to be cost-prohibitive. Donald Walker Dep. at 9-12; BWC Supp. at 65-68.

Appellant UDF similarly participated in the Retro program from July 1, 1989 to September 30, 1995 and became self-insured as of October 1, 1995. Comp. ¶ 6; Sec. BWC at 3. UDF also

signed a 1995 buy-out agreement. BWC Supp. at 35. As with Frisch's, because of the declared surplus, UDF was not required to pay a buy-out fee. Marilyn Mitchell Dep. at 22; BWC Supp. at 57.

Appellant Harris participated in the Retro program from July 1, 1992 to June 30, 1996. Comp. ¶ 7; BWC Supp. at 4. Effective July 1, 1996, Harris also became a self-insured employer. Comp. ¶ 7; BWC Supp. at 4. As with Frisch's and UDF, Harris signed a 1995 buy-out agreement. BWC Supp. at 36. And, as with Frisch's and UDF, the buy-out fee for Harris was waived. As with Frisch's, the waiver was a significant factor in Harris' decision to become self-insured, as the fee would have been in the three- to five-hundred-thousand dollar range. David Jacobs Dep. at 11-12; BWC Supp. at 54-55.

During the years the Bureau declared a surplus, it found that employers such as Frisch's, UDF, and Harris ("self-insured Appellants") were not eligible for premium rebates because they were self-insured and not active participants in the Retro program.

Appellant PH&B participated in the Retro program from July 1, 1995 to June 30, 1998 and from July 1, 2000 to June 30, 2001. Comp. ¶ 8; BWC Supp. at 4. During the rest of the 1995 to 2002 rebate years, PH&B was a group-rated State Fund subscriber. Comp. ¶ 8; BWC Supp. at 4. During the years PH&B was a group-rated participant, it received rebates on the group-rated premiums it paid. Jerry Govert Dep. at 30; BWC Supp. at 39. On September 23, 1999, in exchange for a settlement payment of \$218,059.39, representing a lump-sum reimbursement for premium rebates PH&B should have, but had not, received for payments it made for coverage under the Retro program, PH&B released the Bureau from any and all claims "arising out of the determination of any amounts due to it under the calculation or recalculation of the dividends and/or rebate for the calendar years 1996, 1997, and 1998." BWC Supp. at 37. As with the self-

insured Appellants, the Bureau found that PH&B was not eligible for premium rebates on the annual and final adjustment Retro program payments it made while it actively paid premiums for and participated in the group-rated program.

E. Appellants Frisch's, UDF, Harris and PH&B sued for premium rebates for the annual and final adjustment payments they made while they were not active in the Retro program; the trial court and court of appeals denied them the rebates.

Frisch's, UDF, Harris and PH&B sued Defendant-Appellee James G. Conrad, previous Administrator of the Ohio Bureau of Workers' Compensation, for a declaration that the Bureau unlawfully refused to grant them premium rebates or reductions for those rebate years in which they made Retro look-back payments or final adjustments for previous years, but for which their risks for the rebate year were not covered under the Retro program. Appellants filed a Motion for Class Certification, which was denied by the trial court and the Tenth District Court of Appeals, and on which this Court declined jurisdiction. *Frisch's Restaurants, Inc. v. Mabe*, No. 2005-2257; 3/29/2006 Case Announcements 2006-Ohio-1329.

On the merits, Appellants and the Bureau filed Cross-Motions for Summary Judgment. The trial court denied Appellant's motion and granted the Bureau's motion. Appellants' Appendix at 21-38. The Tenth District Court of Appeals affirmed the trial court on February 8, 2007. Appellant's Appendix at 3-19. This Court accepted jurisdiction on July 27, 2007. *Frisch's Restaurants, Inc. v. Ryan*, No. 2007-0544; 7/27/2007 Case Announcements 2007-Ohio-3699.

ARGUMENT

The dispute here largely comes down to the meaning of the word "subscriber" in R.C. 4123.32(A), and who has authority to determine its meaning. The word is not defined in the statute or elsewhere in the code. As explained above, the statute gives the Administrator discretion as to when premium rebates are appropriate, and states that the rebates are to be

returned “to the subscriber to the fund.” R.C. 4123.32(A). The rule promulgated under that statute, OAC 4123-17-10, further gives the Administrator the discretion to determine who is a “subscriber”: “The administrator . . . shall have the discretion and authority to determine . . . *the employers who are subscribers to the state insurance fund who are eligible for the cash refunds or reduction of premiums . . . and any other issues involving cash refunds or reduction of premiums due to an excess surplus of earned premium.*” OAC 4123-17-10 (emphasis added). Thus, the statute and rule give the Administrator discretion to determine who is a “subscriber” within the meaning of a premium rebate program.

Appellants here interpret the word “subscriber” differently than did the Administrator, and want the Court to substitute their reading for the Administrator’s. Appellants assert that, as a part of the Retro program, they continued to pay annual adjustment “premiums” even during the years in which they were self-insured or under the group-rated program. For those years in which dividend credits were declared, but in which the Appellants’ risk was not covered by the Retro program, they claim entitlement to premium rebates on the annual “look back” and final adjustment payments for earlier years’ Retro program coverage.

Conversely, the Administrator interprets the word “subscriber” to mean only those employers whose workers’ compensation risk is covered by a particular program in the rebate year. In other words, a self-insured employer, whose risk for the rebate year is not covered by the Retro program, is not eligible for a premium rebate, even if that employer is making “look back” and final adjustment payments for earlier, non-rebate years. Alternately, a group-rated employer is eligible for premium rebates only for the group-rated premiums it pays for the rebate year, not for “look back” and final adjustment payments for earlier, non-rebate years.

Moreover, Frisch's, UDF and Harris got the benefit of the surplus status when the Administrator exercised discretion in waiving the buy-out fee for employers switching to self-insured status. Indeed, such waivers are worth hundreds of thousands to millions of dollars.

As explained in detail below, the Administrator's interpretation is reasonable, is not an abuse of discretion, and does not violate equal protection. This Court, as did the courts below, should defer to the Administrator's reasonable interpretation of "subscriber" in R.C. 4123.32(A) and affirm.

Appellee Administrator's Proposition of Law No. 1²

The Administrator was reasonable in interpreting the word "subscriber" in R.C. 4123.32(A) to mean only those employers who are paying premiums to cover risk in the premium rebate year.

A. An administrative agency is owed deference in its interpretation of its own statutes and rules.

The Court has repeatedly held that it gives an administrative agency due deference when interpreting its own statutes, and promulgating and interpreting its own rules. "It is axiomatic that if a statute provides the authority for an administrative agency to perform a specified act, but does not provide the details by which the act should be performed, the agency is to perform the act in a reasonable manner based upon a reasonable construction of the statutory scheme." *Northwestern Ohio Bldg. & Constr. Trades Council v. Conrad*, 92 Ohio St. 3d 282, 287-288, 2001-Ohio-190. See also, *Swallow v. Industrial Commission* (1988), 36 Ohio St. 3d 55, 57 ("A court must give due deference to the agency's reasonable interpretation of the legislative scheme," and "It is a well-settled rule that courts, when interpreting statutes, must give due

² Appellee Administrator's Proposition of Law No.1 is in response to Appellant's Proposition of law No. I, which states: "The term subscriber as used in R.C. 4123.32(A) must be interpreted in accordance with legislative rules of statutory construction. Where the intent of the legislature can be discerned from those rules, defining the term is not a matter within the discretion of the Ohio Bureau of Workers' Compensation."

deference to an administrative interpretation formulated by an agency that has accumulated substantial expertise, and to which the General Assembly has delegated the responsibility of implementing the legislative command,” citing *State ex rel. McLean v. Industrial Commission* (1986), 25 Ohio St. 3d 90, 92); *Jones Metal Products Co. v. Walker* (1972), 29 Ohio St. 2d 173; *State ex rel. Clark v. Great Lakes Constr. Co.*, 99 Ohio St. 3d 320, 2003-Ohio-3802 ¶ 10 (“It is a fundamental tenet of administrative law that an agency’s interpretation of a statute that it has the duty to enforce will not be overturned unless the interpretation is unreasonable.”); *Sandusky Dock Corp. v. Jones*, 106 Ohio St. 3d 274, 2005-Ohio-4982 ¶ 8 (“[W]e will give due deference to the director’s ‘reasonable interpretation of the legislative scheme’ governing his agency.”). See also *State ex rel. Schaengold v. Ohio Pub. Employees Ret. Sys.*, 114 Ohio St. 3d 147, 2007-Ohio-3760; *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.* (1984), 467 U.S. 837, 843 (“if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency’s answer is based on a permissible construction of the statute”).

In this case, the term “subscriber” is not defined anywhere in the Workers’ Compensation Act or in the case law interpreting it. In addition, as the court below pointed out, “the term ‘subscriber’ is one of the broadest possible interpretation, and the context in which the word appears in R.C. 4123.32(A) does not provide much guidance to establish what specific meaning this might imply in the framework of premium rebate allowance.” *Frisch’s Rests., Inc. v. Conrad*, 170 Ohio App. 3d 578, 2007-Ohio-545 at ¶ 21; Appellant’s Appendix (“Appx.”) at 12-13. And because little guidance is provided, the Administrator’s interpretation of the term is due great deference.

Appellants’ attempt to distinguish *Northwestern* and *Swallow* is without merit. Appellants argue that both cases involved judgment regarding the Industrial Commission’s policy on a

matter where the relevant statutes were silent as to certain factors or details. Appellants' Brief at 24-26. Yet, that is exactly what is at issue in this case. As Appellants concede, while R.C. 4123.32(A) and OAC 4123-17-10 grant the Bureau the authority and discretion to determine which employers are subscribers eligible to receive premium rebates or credits, the statutes and code are silent as to the definition of the term "subscriber." Thus, as in *Northwestern and Swallow*, the Legislature has created a "gap" for which an administrative agency has the power to "formulate policy and the making of rules to fill any gap left, implicitly or explicitly by the legislature." *Morton v. Ruiz* (1974), 415 U.S. 199, 231.

The General Assembly meant the Administrator to fill in the missing details with regard to a rebate program in a reasonable manner. And as explained further below, that is what the Administrator has done.

B. The Administrator was reasonable and within his discretion to interpret the word "subscriber" to mean only those employers who pay premiums to cover their workers' compensation risk for the premium rebate year, and not those making only "look-back" and final adjustment payments to cover the risk for non-rebate years.

The Administrator reasonably interpreted the undefined term "subscriber" in the context of the premium rebate provisions of R.C. 4123.32(A) to mean only those employers who pay premiums to cover their risk for the rebate year, and to apply only to premiums paid in the program the employer is participating in for the rebate year. The Court should therefore defer to that reasonable interpretation, and affirm the court below.

Appellants largely rely on the argument that the interpretation of "subscriber" should be the same as the definition for "state risk" in OAC 4123-19-01(A). However, the self-insured Appellants, Frisch's, UDF and Harris, do not meet the definition of a "state risk" under OAC 4123-19-01 for the years in which they are self-insured, because they do not pay their full premium into the fund for those years:

(A) “State risks” are hereby defined as those employers who pay their *full premium* into the state insurance fund.

OAC 4123-19-01(A) (emphasis added). Thus, for a year that an employer is self-insured, it pays *none* of its premium for the current year into the state insurance fund, and therefore is not a “state risk.” And even if the employer is currently self-insured but still makes “look-back” and final adjustment payments into the fund for previous years in which it was in the Retro program, it still cannot—under any definition—be said to “pay [its] full premium” into the Fund. That is because it pays only *part* of the premiums for previous years, and *none* for the current year. The self-insured Appellants here do not meet any plausible definition of a “state risk.” Thus, self-insured Appellants’ arguments equating “state risk” and “subscriber” are inapposite.

Nor is there a “dual” legal status for self-insured employers, as the self-insured Appellants suggest. Neither the Revised Code nor the Administrative Code recognizes such a dual status for any purpose whatsoever, let alone for purposes of premium rebates. Just because self-insured employers pay their “look-back” and final adjustment payments for previous Retro plan coverage does not give an employer a dual legal status. While self-insured Appellants’ payment obligations may have continued beyond the coverage year, their insurance coverage did not. For example, if an employer participated in the Retro program for the 1994 policy year, it had workers’ compensation coverage through the State Fund for any claims or related costs filed during 1994. The annual adjustment and final payments required during the 10 years after 1994 do not extend the employer’s coverage beyond 1994, but rather pertain only to amounts paid for claims filed in 1994. In 1995, when Frisch’s, UDF and Harris became self-insured, their workers’ compensation coverage for 1995 and subsequent years no longer derived from the State Fund, and they were no longer “state risks.” After 1994, Frisch’s, UDF’s and Harris’s payments to the Bureau were only for claims covered and paid by the State Fund for 1994 and prior years.

The Administrator was reasonable in not awarding premium rebates to the self-insured Appellants, because they neither meet the definition of a “state risk,” nor do they hold some extra-statutory “dual status.”

Moreover, while PH&B meets the definition of “state risk” for the years in dispute, nothing in the statute or rules requires the rebates they demand. Just because they are a state risk under the group rating program in a particular year does not mean that they are entitled to rebates for “look back” and final adjustment payments for previous years in which they participated in the Retro program.

Nor is it unreasonable for the Administrator to grant rebates for “look back” and final adjustment payments for previous years to employers in the Retro program during the rebate year. A non-Retro State Fund employer during a rebate year not only gets a rebate for its premium for that year, but all workers’ compensation risk for that year is covered by the State Fund in perpetuity. But employers who were in the Retro program for a rebate year must continue for ten years to reimburse the fund for any liability for the rebate year, even if a rebate will not be available for those later “look back” and final adjustment payments. It is therefore reasonable to give Retro employers a rebate for “look back” and final adjustment payments made in the rebate years for previous years, as a rough equivalent for the later payments for the rebate year that will not be rebated. PH&B received rebates for its group rating premiums for those rebate years it was in the group rating system, and has *no* future liability for “look back” and final adjustments for those years, and therefore no need for rebates for Retro payments from non-rebate years.

In short, the Administrator reasonably awarded rebates to each “subscriber” to the fund for payments made to the program in which that employer was a subscriber in that rebate year. This

is a consistent and reasonable reading of “the administrator may return such excess surplus to the subscriber to the fund” in R.C. 4123.32(A). And, as the Tenth District stated below, “regardless of whether alternative interpretations more satisfactory to appellants might be substituted, we apply the principle of administrative deference under *Northwestern* and consider only the reasonableness of the interpretation applied by the Bureau.” 2007-Ohio-545 at ¶ 21; Appellant’s Appx. at 12-13. This Court should do the same.

C. The classification of various employers that results from the Administrator’s interpretation of the word “subscriber” in R.C. 4123.32(A) does not violate equal protection, because it is rationally related to a legitimate government interest.

Any classification that results from the Administrator’s interpretation of the word “subscriber” in R.C. 4123.32(A) is rationally related to a legitimate government interest, and therefore does not violate equal protection. A statutory classification that involves neither a suspect class nor a fundamental right will not violate the guarantees of equal protection in the U.S. and Ohio Constitutions, if it bears a rational relationship to a legitimate government interest. *Menefee v. Queen City Metro* (1990), 49 Ohio St. 3d 27, 29, citing *Metropolitan Life Ins. Co. v. Ward* (1985), 470 U.S. 869, 881.

In this case, Appellants do not argue, nor can they, that they have a fundamental right to premium rebates. Indeed, this Court’s holding in *Copperweld Steel Co. v. Industrial Commission* (1944), 143 Ohio St. 591, established that employers have no property right—let alone a fundamental right—in the State Fund. Nor is an employer leaving the State Fund to become self-insured entitled to a return of excess premiums paid into the Fund. *Cuyahoga Metropolitan Housing Authority v. Industrial Commission* (1983), 11 Ohio App. 3d 192.

Moreover, Appellants are not really in the same “class” as employers currently in the Retro program during rebate years. Employers in the Retro program during a rebate year receive rebates not only for that year’s premium, but also for their “look-back” and final adjustment

payments for previous years. Employers like the Appellants here, while not receiving rebates for their “look-back” and final adjustment payments for previous years, received other benefits that current Retro employers did not.

Frisch’s, UDF and Harris received the benefit of achieving self-insured status without having to pay the buy-out fee—a benefit worth hundreds of thousands to several million dollars. Herf Dep. at 61, BWC Supp. at 44. And, as explained above, in the case of PH&B, as a member of the group rating system for some of the rebate years, all workers’ compensation risk for those years is covered by the State Fund in the future. But employers who were in the Retro program for those years must continue for ten years to reimburse the fund for any liability for the rebate year, even if a rebate is not available for those later “look back” and final adjustment payments. The Administrator gives these employers a rebate for “look back” and final adjustment payments made in the rebate years for previous years as a rough equivalent for the later payments that will not be rebated. PH&B received rebates for its group rating premiums for those rebate years it was in the group rating system, and has *no* future liability for “look back” and final adjustments for those years. Thus, Appellants are not similarly situated to those employers in the Retro program during a rebate year.

Moreover, as both courts below recognized, the various employers were treated equally, because all self-insured employers are denied rebates, and all state fund employers receive rebates in only one program at a time—the program in which they actively participate at the time the rebate is declared. Decision and Entry at 9; Appellant’s Appx. at 29; 2007-Ohio-545 at ¶ 21; Appellant’s Appx. at 12-13. The real difference between employers is the difference between the various programs for insuring workers’ compensation risk, not the method of rebate, which is the same for everyone.

Thus, the Administrator's rebate program is rationally related to a legitimate government interest. The legitimate government interest is in rebating excess premiums in the Fund to employers participating in the Fund. And the Bureau's policy of awarding dividend credits based on the one program through which the employer obtained its insurance coverage for that year is rational because an employer can meet a particular year's coverage obligations through only one program at a time.

D. The administrative regulation here does not conflict with the statute.

Nor, as argued by Appellants, is the Administrator's interpretation faulty because of a conflict between the enabling statute and the implementing regulation. As explained above, the statute and rule aim at the same target. R.C. 4123.32(A) gives the Administrator discretion to "return such excess surplus to the subscriber to the fund," and to promulgate a rule allowing the return, without defining the word "subscriber." The regulation gives the Administrator the discretion to determine who is a subscriber, also without defining the term: "The administrator . . . shall have the discretion and authority to determine . . . the employers who are subscribers to the state insurance fund who are eligible for the cash refunds or reduction of premiums" OAC 4123-17-10.

The two provisions do not conflict, because they both indicate that "subscribers to the fund" are to get rebates. This is unlike the provisions at issue in the case cited by Appellants, *Hoffman v. State Med. Bd. of Ohio*, 113 Ohio St. 3d 376, 2007-Ohio-2201. In *Hoffman*, the statute at issue allowed anesthesiology assistants ("AAs") to "assist" in a particular procedure, whereas the rule at issue prohibited the AAs from performing the procedure. Thus the question there was whether "assist" meant to "perform," because if so, the statute allowed what the rule prohibited.

Here no such conflict exists. The regulation does not prohibit what the statute permits, or vice versa. The term at issue, “subscriber,” is the same in both statute and rule, and is undefined in both. Thus *Hoffman* is inapposite.

Appellee Administrator’s Proposition of Law No. 2³

The Administrator was reasonable and not inconsistent with prior practice in denying certain employers the legal status of “subscriber” under R.C. 4123.32(A).

The Appellants also object to the Administrator’s definition of “subscriber” as “unreasonable and unlawful as a matter of law.” For the reasons below, their arguments are without merit.

First, Appellants’ argument that they are State Fund subscribers because, as self-insured employers, they remain eligible for certain surplus reimbursements ignores two facts: (1) the reimbursements afforded by R.C. 4123.343, 4123.511 and 4121.66 are not insurance coverage; they are incentives designed to promote the employment of disabled individuals and the rehabilitation of injured workers; and (2) the language of each of the statutes makes a distinction between State Fund participants and self-insured employers, thus making it clear that they are two separate and distinct legal statuses, and that there is no such thing a “dual status.”

Nor is their reliance on *Cleveland v. Industrial Commission* (1983), 8 Ohio App. 3d 7 apposite here. In *Cleveland*, the Industrial Commission had no regulations whatsoever for re-billing employers who had underpaid. The Court therefore held the Commission to its past practice of not re-billing more than two years after the underpayment. Here, there is no history whatsoever of rebate payments, or the meaning of “subscriber,” whereas there is a regulation

giving the Administrator the discretion to determine who is a “subscriber.” The Bureau’s past treatment of employers for the purposes of handicap and rehabilitation incentives is irrelevant to the interpretation of a regulation about premium rebates.

Second, the Administrator here, as discussed above, has not violated the Appellants’ constitutional rights, as happened in *State ex rel. Sysco Food Serv. of Cleveland v. Industrial Commission*, 89 Ohio St. 3d 612, 2000-Ohio-1. In *Sysco*, the self-insured employer was denied the right to recover from the Surplus Fund for benefits it had paid in an ultimately-disallowed claim. The *Sysco* Court held that it violated the right-to-remedy provision of the Ohio Constitution not to allow self-insured employers to continue to recover from the Surplus Fund. This is wholly unlike this case, where the Appellants have failed even to assert that their right to a remedy has been violated.

Third, the Administrator’s rebate policy fully conforms with the General Assembly’s intent. As discussed above, R.C. 4123.32(A) authorizes the promulgation of a rule setting up a rebate program, and leaving most of the details to “the judgment of the administrator.” The General Assembly did not define the word “subscriber,” or otherwise indicate who would be eligible for the rebates, but left it to the discretion of the Administrator. This is wholly unlike the situation in *Arth Brass*, where the statute categorically proscribed the policy the Bureau had implemented: “[t]he statute sets forth a flat prohibition – ‘shall not be charged.’” *Arth Brass & Aluminum Castings, Inc. v. Conrad*, 104 Ohio St. 3d 547, 2004-Ohio-6888 at ¶ 33.

³ Appellee Administrator’s Proposition of Law No. 2 is in response to Appellant’s Proposition of Law No. II, which reads: “Where the Bureau of Workers’ Compensation practice of denying certain employers the legal status of a R.C. 4123.32(A) subscriber is inconsistent with its past administrative practices, and where such practice effects disparate treatment among premium paying employers for which the BWC offers no factual justification, its practice is unreasonable and unlawful as a matter of law.”

Fourth, the Administrator received advice and consent on the rebate policy from the Oversight Commission, as illustrated by the Commission resolutions. Appellants' Supp. at 1-16. Contrary to the Appellants' arguments, the resolutions do not specifically include self-insured employers within the definition of "subscriber" nor do they order the Bureau to grant refunds to "all" subscribers "without exception" as Appellants suggest in their Brief at page 30. In fact, the resolutions specifically direct the Bureau to apply the premium reductions "to private employers who are subscribers to the State Insurance Fund for *total premium and assessment payments due on payroll reports for the subject payroll period.*" Oversight Commission Resolutions; Appellants' Supp at 1-16. By their very language, the resolutions exclude premium rebates for self-insured employers because self-insured employers do not pay premiums based on payroll reports. They do not even submit payroll reports. Furthermore, employers previously enrolled in the Retro program still paying annual and final adjustment payments are not paying those premiums or assessments based on their payroll reports. Thus, contrary to Appellants' argument, the Bureau followed the resolutions exactly.

Appellee Administrator's Proposition of Law No. 3

The courts below should be affirmed on the alternate ground that appellants waived all rights to challenge premium rebates.

Although neither the trial court nor the court of appeals below reached the issue, the Administrator pointed out at each level below that Appellants released their claims to any unpaid premium rebates, and therefore waived any right to bring this lawsuit.

Waivers and general releases are executed precisely to protect against unanticipated future claims such as the ones made here. *Task v. National City Bank* (1994), 1994 Ohio App. Lexis 437 Appendix ("Appx.") at A-6 (upholding enforceability of waiver regarding future unknown claims). As the release signed by each self-insured Appellant here is expressed in clear and

unequivocal terms, it should be enforced. *Jacob v. Grant Life Choices Fitness Center, Club Management, Inc.* (1996), 1996 Ohio App. Lexis 2313 at *6. Appx. at A-18

The self-insured Appellants each executed a buy-out agreement when they moved from State Fund to self-insured status. The buy-out agreement is a one-page form, and all of the pertinent language is expressed in a single, legible, uniform font. Contained in the standardized “buy-out agreement” form is a release, which states:

“The employer, its assigns and successors in interest expressly waives forever any claims for premium or loss adjustments not expressly contained in this agreement.”

The waiver specifically includes claims for “premium” adjustments. The Bureau revised the buy-out waiver in 1999 to specifically include “any future rebates or dividends,” but “this was not an admission that the 1995 agreement was not intended to waive future claims . . .” BWC Supp. at 33.

Thus, Frisch’s, UDF and Harris waived any claims for a premium adjustment, including a refund or dividend credit. Premium adjustments, in the form of refunds, were obviously within the contemplation of the parties because such refunds and dividends were authorized by R.C. 4123.32(A) at the time the self-insured Appellants signed the release. By executing the buy-out agreement, Frisch’s, UDF, and Harris intended to relinquish their rights to bring future claims for refunds in return for the privilege of being self-insured. And the Bureau expected to be protected against such claims in return for granting Appellants that privilege.

Similarly, under a settlement agreement signed September 23, 1999 in consideration of the sum of \$218,059.39, PH&B released the Bureau from all liability for any claim “on account of or in any way arising out of the determination of any amounts due to [PH&B] under the calculation or recalculation of the dividends and/or rebate for the calendar years 1996, 1997, and 1998.” BWC Supp. at 37. Settlement agreements are highly favored by the law. *Continental W.*

Condominium Unit Owners Assn. v. Howard E. Ferguson, Inc., 74 Ohio St. 3d 501, 502, 1996-Ohio-158. Furthermore, a settlement agreement is an enforceable contract under Ohio law. *Id.*; *Kostelnik v. Helper* (2002), 96 Ohio St. 3d 1, 2002-Ohio-2985, ¶ 15.

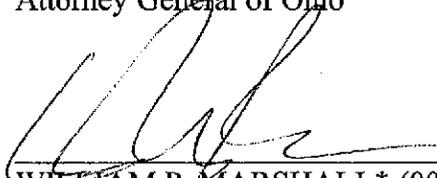
Moreover, Appellants fail to offer—either here or in any court below—any authority, evidence, or cogent analysis to circumvent the clear waiver language of the buy-out and settlement agreements. Accordingly, the Court should affirm because Appellants released and waived any claims to the rebates.

CONCLUSION

For the above reasons, this Court should affirm.

Respectfully submitted,

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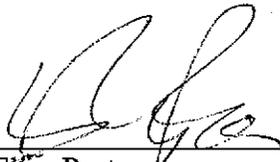
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CERTIFICATE OF SERVICE

I certify that a copy of the foregoing Merit Brief of Appellee Marsha P. Ryan, Administrator, Ohio Bureau of Workers' Compensation was served by U.S. mail this 4th day of December, 2007, upon the following counsel:

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APPENDIX

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*** ARCHIVE MATERIAL ***

*** CURRENT THROUGH LEGISLATION APPROVED THROUGH MARCH 29, 2004 ***
 *** ANNOTATIONS CURRENT THROUGH DECEMBER 31, 2003 ***

TITLE 41. LABOR AND INDUSTRY
 CHAPTER 4121. INDUSTRIAL COMMISSION; BUREAU OF WORKERS' COMPENSATION
 REHABILITATION OF INJURED WORKERS

ORC Ann. **4121.66** (2004)§ **4121.66**. Payments from surplus fund or directly by self-insuring employer

(A) The administrator of workers' compensation shall pay the expense of providing rehabilitation services, counseling, training, and living maintenance payments from the surplus fund established by [section 4123.34 of the Revised Code](#).

(B) Living maintenance payments are not subject to garnishment, levy, or attachment.

(C) [Sections 4123.343 \[4123.34.3\]](#), [4123.63](#), and [4123.64 of the Revised Code](#) do not apply to living maintenance payments.

(D) A self-insuring employer under [section 4123.35 of the Revised Code](#) may elect to pay directly to a claimant or to the provider of the rehabilitation services, counseling, or training the expenses listed in division (A) of this section by filing an application with the bureau of workers' compensation not more than one hundred eighty days and not less than ninety days prior to the first day of the employer's next six-month coverage period. If the self-insuring employer timely files the application, the application is effective on the first day of the employer's next six-month coverage period, provided that the administrator shall compute the employer's assessment for the surplus fund due with respect to the period during which such application was filed without regard to the filing of the application. Following the timely filing, the self-insuring employer shall pay directly to a claimant or to the provider of the rehabilitation services, counseling, or training the expenses listed in division (A) of this section for all periods of rehabilitation occurring on or after the effective date of his election, regardless of the date of the injury or occupational disease, and he shall receive no money or credits from the surplus fund on account of such payments and shall not be required to pay any amounts into the surplus fund on account of this section, provided that for a period not to exceed one hundred eighty days after the effective date of the application, the self-insuring employer may submit to the bureau requests for reimbursement from the surplus

fund on account of payments made for services rendered or living maintenance periods prior to the effective date of the application pursuant to division (A) of this section. The election made under this division is irrevocable.

HISTORY: 138 v H 138 (Eff 7-27-79); 145 v H 107. Eff 10-20-93.

NOTES:

The effective date is set by section 21 of HB 107.

CROSS-REFERENCES TO RELATED STATUTES

Considerations and requirements in fixing rates; assessment of self-insuring employers; security fund; discounts, [RC § 4123.34](#).

Incentives for employing handicapped employees; definitions, [RC § 4123.34.3](#).

Payment of premiums; certificate of payment; granting of self-insuring employer status, [RC § 4123.35](#).

OHIO ADMINISTRATIVE CODE

General rating for state insurance fund --

Self-insuring employer assessments based upon paid compensation. *OWCH:* [OAC 4123-17-32](#).

Vocational rehabilitation --

Fees for use of services of bureau rehabilitation center. *OWCH:* [OAC 4123-18-22](#).

Living maintenance allowance. *OWCH:* [OAC 4123-18-04](#).

Payment for rehabilitation services and related expenses from the surplus fund. *OWCH:* [OAC 4123-18-08](#).

TEXT DISCUSSION

Rehabilitation. *Ohio Workers' Comp.* § 10.2

RESEARCH AIDS

Rehabilitation services:

[O-Jur3d: Workers' Comp § 263](#)

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ORC Ann. 4123.343

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*** CURRENT THROUGH LEGISLATION PASSED BY THE 127TH OHIO GENERAL ASSEMBLY
 AND FILED WITH THE SECRETARY OF STATE THROUGH NOVEMBER 8, 2007 ***

*** ANNOTATIONS CURRENT THROUGH OCTOBER 1, 2007 ***

*** OPINIONS OF ATTORNEY GENERAL CURRENT THROUGH NOVEMBER 4, 2007 ***

TITLE 41. LABOR AND INDUSTRY
 CHAPTER 4123. WORKERS' COMPENSATION
 PREMIUMS; FUNDS

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ORC Ann. **4123.343** (2007)

§ **4123.343**. Incentives for employing handicapped employees; definitions

This section shall be construed liberally to the end that employers shall be encouraged to employ and retain in their employment handicapped employees as defined in this section.

(A) As used in this section, "handicapped employee" means an employee who is afflicted with or subject to any physical or mental impairment, or both, whether congenital or due to an injury or disease of such character that the impairment constitutes a handicap in obtaining employment or would constitute a handicap in obtaining reemployment if the employee should become unemployed and whose handicap is due to any of the following diseases or conditions:

- (1) Epilepsy;
- (2) Diabetes;
- (3) Cardiac disease;
- (4) Arthritis;
- (5) Amputated foot, leg, arm, or hand;
- (6) Loss of sight of one or both eyes or a partial loss of uncorrected vision of more than

seventy-five per cent bilaterally;

- (7) Residual disability from poliomyelitis;
- (8) Cerebral palsy;
- (9) Multiple sclerosis;
- (10) Parkinson's disease;
- (11) Cerebral vascular accident;
- (12) Tuberculosis;
- (13) Silicosis;
- (14) Psycho-neurotic disability following treatment in a recognized medical or mental institution;
- (15) Hemophilia;
- (16) Chronic osteomyelitis;
- (17) Ankylosis of joints;
- (18) Hyper insulinism;
- (19) Muscular dystrophies;
- (20) Arterio-sclerosis;
- (21) Thrombo-phlebitis;
- (22) Varicose veins;
- (23) Cardiovascular, pulmonary, or respiratory diseases of a firefighter or police officer employed by a municipal corporation or township as a regular member of a lawfully constituted police department or fire department;
- (24) Coal miners' pneumoconiosis, commonly referred to as "black lung disease";
- (25) Disability with respect to which an individual has completed a rehabilitation program conducted pursuant to sections 4121.61 to 4121.69 of the Revised Code.

(B) Under the circumstances set forth in this section all or such portion as the administrator determines of the compensation and benefits paid in any claim arising hereafter shall be charged to and paid from the statutory surplus fund created under section 4123.34 of the Revised Code and only the portion remaining shall be merit-rated or otherwise treated as part of the accident or occupational disease experience of the employer. If the employer is a self-insuring employer, the proportion of such costs whether charged to the statutory surplus fund in whole or in part shall be by way of direct payment to such employee or the employee's dependents or by way of reimbursement to the self-insuring employer as the circumstances indicate. The provisions of this section apply only in cases of death, total disability, whether temporary or permanent, and all disabilities compensated under division (B) of section 4123.57 of the Revised Code. The administrator shall adopt rules specifying the grounds upon which charges to the statutory surplus fund are to be

made. The rules shall prohibit as a grounds any agreement between employer and claimant as to the merits of a claim and the amount of the charge.

(C) Any employer who has in its employ a handicapped employee is entitled, in the event the person is injured, to a determination under this section.

An employer shall file an application under this section for a determination with the bureau or commission in the same manner as other claims. An application only may be made in cases where a handicapped employee or a handicapped employee's dependents claim or is receiving an award of compensation as a result of an injury or occupational disease occurring or contracted on or after the date on which division (A) of this section first included the handicap of such employee.

(D) The circumstances under and the manner in which an apportionment under this section shall be made are:

(1) Whenever a handicapped employee is injured or disabled or dies as the result of an injury or occupational disease sustained in the course of and arising out of a handicapped employee's employment in this state and the administrator awards compensation therefor and when it appears to the satisfaction of the administrator that the injury or occupational disease or the death resulting therefrom would not have occurred but for the pre-existing physical or mental impairment of the handicapped employee, all compensation and benefits payable on account of the disability or death shall be paid from the surplus fund.

(2) Whenever a handicapped employee is injured or disabled or dies as a result of an injury or occupational disease and the administrator finds that the injury or occupational disease would have been sustained or suffered without regard to the employee's pre-existing impairment but that the resulting disability or death was caused at least in part through aggravation of the employee's pre-existing disability, the administrator shall determine in a manner that is equitable and reasonable and based upon medical evidence the amount of disability or proportion of the cost of the death award that is attributable to the employee's pre-existing disability and the amount found shall be charged to the statutory surplus fund.

(E) The benefits and provisions of this section apply only to employers who have complied with this chapter either through insurance with the state fund or as a self-insuring employer.

(F) No employer shall in any year receive credit under this section in an amount greater than the premium the employer paid if a state fund employer or greater than the employer's assessments if a self-insuring employer.

(G) Self-insuring employers may, for all claims made after January 1, 1987, for compensation and benefits under this section, pay the compensation and benefits directly to the employee or the employee's dependents. If such an employer chooses to pay compensation and benefits directly, the employer shall receive no money or credit from the surplus fund for the payment under this section, nor shall the employer be required to pay any amounts into the surplus fund that otherwise would be assessed for handicapped reimbursements for claims made after January 1, 1987. Where a self-insuring employer elects to pay for compensation and benefits pursuant to this section, the employer shall assume responsibility for compensation and benefits arising out of claims made prior to January 1, 1987, and shall not be required to pay any amounts into the surplus fund and may not receive any money or credit from that fund on account of this section. The election made under this division is irrevocable.

(H) An order issued by the administrator pursuant to this section is appealable under section 4123.511 [4123.51.1] of the Revised Code but is not appealable to court under section 4123.512 [4123.51.2] of the Revised Code.

Service: Get by LEXSEE®

Citation: 1994 Ohio App. lexis 437

*1994 Ohio App. LEXIS 437, **

BURTON J. TASK, et al, Plaintiff-appellants v. NATIONAL CITY BANK, et al, Defendant-appellees

NO. 65617

COURT OF APPEALS OF OHIO, EIGHTH APPELLATE DISTRICT, CUYAHOGA COUNTY

1994 Ohio App. LEXIS 437

February 10, 1994, Announced

NOTICE:

[*1] THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

PRIOR HISTORY: CHARACTER OF PROCEEDING: Civil appeal from Court of Common Pleas. Case No. 221,239

DISPOSITION: JUDGMENT: AFFIRMED.

CASE SUMMARY

PROCEDURAL POSTURE: Appellants, leasing agency, its president, and his wife, challenged the order of the Cuyahoga County Court of Common Pleas (Ohio), which granted summary judgment in favor of appellee bank in appellants' action against the bank for breach of contract, tortious interference, and lender liability.

OVERVIEW: The leasing agency entered into an operating agreement with the bank whereby the bank agreed to finance the leasing agency's business. This action derived from that banking relationship. The bank sought summary judgment and asserted that the action was barred under the doctrine of res judicata by a release executed between the parties in settlement of a prior case. The trial court granted summary judgment for the bank, and this appeal followed. The court affirmed the judgment. Because summary judgment was granted without opinion, the court had no way of knowing on what grounds the decision was based. Thus, the court had the authority to uphold the judgment if either basis was appropriate. Because the president did not challenge the trial court's apparent determination that the claims were barred by the doctrine of res judicata, the judgment was affirmed for that reason alone. Regardless, the judgment was affirmed because under the unambiguous terms of the release, the president released all claims asserted. Moreover, there was no evidence that raised a question of material fact on the issue of mutual mistake by the parties in entering the release.

OUTCOME: The court affirmed the order of the trial court that granted summary judgment for the bank.

CORE TERMS: summary judgment, settlement, issue of material fact, genuine, matter of law, common pleas, sub judice, res judicata, unknown, causes of action, releasor, counterclaim, banking, assign, lender, leases, genuine issue, material fact, moving party, burden of production, legal effect, mutual mistake, substantiate, unambiguous, accelerated, fraudulent, releasing, nonmoving, manifest, signing

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HN1  A party, on appeal, must set forth his assigned errors and all arguments in support of those alleged errors. [Ohio R. App. P. 12\(A\)](#) states that errors not specifically pointed out in the record and separately argued by brief may be disregarded. [More Like This Headnote](#)

[Civil Procedure](#) > [Summary Judgment](#) > [Appellate Review](#) > [Standards of Review](#) 

[Civil Procedure](#) > [Appeals](#) > [Standards of Review](#) > [De Novo Review](#) 

HN2  The reviewing court's analysis of an appeal from a summary judgment is conducted under a de novo standard of review. No deference is given to the decision under review, and the reviewing court applies the same test as the trial court. [More Like This Headnote](#)

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[Civil Procedure](#) > [Summary Judgment](#) > [Standards](#) > [Materiality](#) 

HN3  It is well settled that summary judgment is appropriate only when all of the following have been established: (1) that there is no genuine issue as to any material fact; (2) that the moving party is entitled to judgment as a matter of law; and (3) that reasonable minds can come to but one conclusion and that conclusion is adverse to the party against whom the motion for summary judgment is made, that party being entitled to have the evidence construed most strongly in its favor. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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[Civil Procedure](#) > [Summary Judgment](#) > [Standards](#) > [Genuine Disputes](#) 

HN4  The burden of showing that no genuine issue exists as to any material fact falls upon the moving party in requesting summary judgment. However, if the moving party contends that there is no evidence on an issue for which the nonmoving party bears the burden of production at trial, the nonmoving party must produce evidence on that issue to substantiate that a genuine issue of material fact remains for trial. [More Like This Headnote](#)

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[General Overview](#) 

HN5  A release ordinarily operates to extinguish a right in exchange for some consideration and effectively operates as an estoppel or a defense to an action by the releasor. As such, it is a contract between parties, enforceable at law subject to the rules governing the construction of contracts. Whether a release operates

upon a certain liability depends entirely upon the intention of the parties, which is to be gathered from the language of the release and the state of facts then existing. If the parties to a release intend to leave some things out of a release, then their intent to do so should be made manifest. When the terms of a contract are unambiguous, courts will not, in effect, create a new contract by finding an intent not expressed in the language employed by the parties. Moreover, when the parties have negotiated the release with the assistance of legal counsel, and both sides have agreed to the language included in the release, there is an assumption that the parties are fully aware of the terms and scope of their agreement. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

[Contracts Law](#) > [Contract Interpretation](#) > [General Overview](#) 

HN6  Where general words alone are used in a release, they are to be construed most strongly against the releasor. When, however, the terms of a release are so general as to include within its terms claims to which the releasing party was ignorant, and thus not within the contemplation of the parties when the release was executed, the release is voidable at the option of either party. [More Like This Headnote](#)

[Contracts Law](#) > [Defenses](#) > [Ambiguity & Mistake](#) > [Mutual Mistake](#) 

HN7  A release may be avoided where the releasor can establish by clear and convincing evidence that it was executed by mutual mistake, as between himself and the releasee, of a past or present fact, material to the release, unless it appears that the parties intended that all claims be relinquished. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

COUNSEL: For plaintiff-appellants: NICHOLAS M. DeVITO, CHRISTOPHER D. KUEBLER, Attorneys at Law, 1000 Terminal Tower, Cleveland, Ohio 44113.

For defendant-appellees: DANIEL R. WARREN, CHRISTOPHER J. MEYER, Attorneys at Law, 1100 National City Bank Bldg., Cleveland, Ohio 44114.

JUDGES: SARA J. HARPER, PRESIDING JUDGE, BLANCHE KRUPANSKY, JUDGE, DONALD C. NUGENT, JUDGE

OPINION BY: PER CURIAM

OPINION

ACCELERATED DOCKET

JOURNAL ENTRY and OPINION

PER CURIAM:

This cause came on to be heard upon the accelerated calendar pursuant to [App. R. 11.1](#) and [Loc. R. 25](#), the records from the Cuyahoga County Court of Common Pleas, the briefs and the oral arguments of counsel.

Plaintiffs-appellants, Burton J. Task, Jeanne Task, Mildred Task and Suburban Auto Lease Co., Inc., appeal from the order of the common pleas court granting summary judgment in favor of defendants-appellees, [National City Bank](#) and National City Credit Corporation

(hereinafter collectively referred to as "National City").

[*2] Appellant Burton Task is the president of Suburban Auto Lease Co., Inc. (hereinafter "Suburban"), an automobile leasing agency. On or about December 5, 1985, Suburban entered into operating agreements with National City whereby National City agreed to finance Suburban's automobile leasing business in exchange for security interests in certain vehicle leases.

Sometime in early 1989, Suburban was in default under the terms and obligations of the operating agreements. Thereafter, on August 24, 1989, the Cuyahoga County Court of Common Pleas entered cognovit judgments in favor of National City against Suburban and Burton and Jeanne Task. Pursuant to these judgments, National City obtained liens on certain real property owned by Burton and Jeanne Task, including their home located in Orange Village in Cuyahoga County, Ohio.

On December 14, 1989, Ameritrust, who held a first mortgage on the Task's Orange Village home, initiated a foreclosure action against the Task's, Case No. 180,513, averring that they were in default under the terms and conditions of their mortgage agreement.

Thereafter, National City filed a complaint in intervention in Case No. 180,513 against Burton Task, alleging **[*3]** an interest in the subject premises by virtue of the judgment liens obtained against Mr. Task by National City in August, 1989.

On or about April 16, 1990, Mr. Task filed an answer to National City's complaint in intervention, denying the allegations made therein. Mr. Task also filed a counterclaim against National City, averring an alleged breach of the operating agreements on the part of National City.

On May 3, 1991, the parties reached a settlement agreement in Case No. 180,513, releasing all of their claims against one another. The settlement agreement first stated that National City, the Tasks and Suburban had reached an agreement as to the settlement of Case No. 180,513, "and further desire to settle and compromise certain disputes and differences to effect a release of all claims, demands, actions and/or causes of action, of any kind or description that the Tasks or Suburban have, or have had, against National City." The agreement next provided that the Tasks would pay National City \$ 66,858.17 of the proceeds from the sale of their Orange Village home to reduce their \$ 257,604.29 indebtedness to National City. Next was the release provision, which the parties focus on in **[*4]** this appeal, and which provided that:

* * * The Tasks and/or Suburban and their respective partners, subsidiaries, affiliates, predecessors, heirs, successors and assigns, and their past, present and future officers, directors, shareholders, employees, executors and administrators hereby release and forever discharge National City Bank and/or National City Credit Corporation and their respective subsidiaries, affiliates, predecessors, successors and assigns, and their past, present and future officers, directors, shareholders or employees from any claims demands, action and/or causes of action, of any kind or description whatsoever, whether arising of contract, tort or otherwise, in law or in equity, which the Tasks and/or Suburban have, or have had against National City Bank and/or National City Credit Corporation * * * (Emphasis added.)

The settlement agreement further provided that, upon execution of the agreement, the Tasks and/or Suburban would deliver a stipulated judgment entry to National City, dismissing with

prejudice their counterclaim against National City. After the agreement was executed, the trial court entered an order dismissing the Tasks' counterclaim [*5] with prejudice and National City's claims without prejudice.

Approximately six months later, on November 6, 1991, Mr. Task and Suburban initiated the case *sub judice* against National City, asserting claims for breach of contract, tortious interference and lender liability. The genesis of Mr. Task's and Suburban's claims against National City was the parties' banking relationship and the operating agreements. Mr. Task and Suburban sought damages from National City in the amount of \$ 5,650,000.00.

Subsequently, on December 9, 1991, Mr. Task and Suburban, joined by new-party plaintiffs Mildred Task and Jeanne Task, filed an amended complaint against National City, repeating, in essence, the claims set forth in the November 6, 1991 complaint. Mildred and Jeanne Task additionally set forth claims against National City for lender liability and conversion of funds.

In its answer, National City set forth the affirmative defense that this action was barred by the release executed by the parties in settlement of Case No. 180,513.

On April 20, 1992, National City moved the trial court to grant summary judgment in its favor, raising two alternative grounds for granting the motion: the [*6] previous release and *res judicata*. On June 5, 1992, the trial court granted summary judgment in National City's favor, without opinion, and the Tasks and Suburban timely commenced this appeal.

In their sole assignment of error, appellants contend that:

THE TRIAL COURT ERRED AS A MATTER OF LAW BY DISMISSING PLAINTIFF-APPELLANTS' COMPLAINT ON THE BASIS THAT THEY FAILED TO ESTABLISH GENUINE ISSUES OF MATERIAL FACT AND ON THE BASIS THAT THE DEFENDANTS-APPELLEES WERE ENTITLED TO A JUDGMENT AS A MATTER OF LAW.

At the outset, we wish to address an argument raised by National City in its appellate brief. National City correctly points out that while Burton Task, Jeanne Task, Mildred Task and Suburban all appeal from the trial court's entry of summary judgment, appellants' brief raises arguments pertaining solely to the propriety of the trial court's grant of summary judgment against Burton Task. Perplexingly, appellants offered no reply to this observation by National City or to National City's contention that Jeanne Task and Mildred Task have waived their right to challenge the trial court's grant of summary judgment against them by failing to argue any purported error in [*7] their appellate brief.

It is beyond dispute that ^{HN1} a party, on appeal, must set forth his assigned errors and all arguments in support of those alleged errors. App. R. 12 (A) states that "errors not specifically pointed out in the record and separately argued by brief may be disregarded." Inasmuch as appellants Jeanne Task and Mildred Task have failed to argue any alleged errors by the trial court in entering summary judgment against them, we are constrained to disregard any error raised on their behalves. Rees v. Heimberger (1989), 60 Ohio App.3d 45, 573 N.E.2d 189; Contel Credit Corp. v. Rosenblatt (1988), 43 Ohio App.3d 113, 539 N.E.2d 708. We turn now to consider the propriety of the trial court's grant of summary judgment in favor of National City and against Burton Task and Suburban.

^{HN2} Our analysis of an appeal from a summary judgment is conducted under a *de novo* standard of review. See, Maust v. Bank One Columbus, N.A. (1992), 83 Ohio App.3d 103, 107, 614 N.E.2d 765; Howard v. Wills (1991), 77 Ohio App.3d 133, 601 N.E.2d 515;

Morehead v. Conley (1991), 75 Ohio App.3d 409, 411, 599 N.E.2d 786. No deference is given to the decision under review, and we apply [*8] the same test as the trial court. See, Bank One of Portsmouth v. Weber (Aug. 7, 1991), Scioto App. No. 1920, unreported. ^{HN3}¶ It is well settled that summary judgment is appropriate only when all of the following have been established: (1) that there is no genuine issue as to any material fact; (2) that the moving party is entitled to judgment as a matter of law; and (3) that reasonable minds can come to but one conclusion and that conclusion is adverse to the party against whom the motion for summary judgment is made, that party being entitled to have the evidence construed most strongly in its favor. Bostic v. Connor (1988), 37 Ohio St.3d 144, 146, 524 N.E.2d 881; State, ex rel. Coulverson v. Ohio Adult Parole Auth. (1991), 62 Ohio St.3d 12, 14, 577 N.E.2d 352.

^{HN4}¶ The burden of showing that no genuine issue exists as to any material fact falls upon the moving party in requesting summary judgment. Mitseff v. Wheeler (1988), 38 Ohio St.3d 112, 115, 526 N.E.2d 798. However, if the moving party contends that there is no evidence on an issue for which the nonmoving party bears the burden of production at trial, the nonmoving party must produce evidence on that issue to substantiate [*9] that a genuine issue of material fact remains for trial. Wing v. Anchor Media, Ltd. of Texas (1991), 59 Ohio St.3d 108, 570 N.E.2d 1095; Stewart v. B. F. Goodrich Co. (June 18, 1993), Washington App. No. 92 CA33, 1993 Ohio App. LEXIS 3241, unreported. With these principles in mind, we turn our attention to the summary judgment motion and evidentiary materials filed in the case *sub judice*.

As stated previously, National City moved the trial court to grant summary judgment in its favor on two alternative grounds: the previous release and *res judicata*. Inasmuch as the trial court granted summary judgment without opinion we have no way of knowing whether the trial court based its decision upon the language of the release or upon the doctrine of *res judicata*. Therefore, we must affirm the judgment of the trial court if either of those bases is appropriate. Baird v. Hosmer (1975), 48 Ohio App.2d 51, 355 N.E.2d 525.

Starting with the latter, National City correctly points out that Mr. Task has not challenged as error the trial court's apparent determination that his claims are barred by the doctrine of *res judicata*. Since Mr. Task has failed to assign error [*10] in this regard, we must assume he does not dispute that summary judgment on this basis was appropriate and, for this reason alone, we should affirm the judgment of the trial court. However, in the interests of fully satisfying our appellate function, we will address Mr. Task's primary contention in this appeal, which is that the trial court's determination that the release barred his claims in the case *sub judice* is contrary to the intention of the parties.

Specifically, Mr. Task contends that at the time he signed the release, he was unaware of the claims asserted in the case *sub judice*. Mr. Task points to the absence of a specific reference to "unknown" or "future" claims in the release. He then argues that the language of the release and his affidavit reveal the parties' intention to except from the release future claims which were unknown to the parties at the time the release was executed. Alternatively, Mr. Task asserts that National City deceived or misled him into signing the release and that, had he known he was waiving his right to assert future, unknown claims, he would not have signed the release. For the reasons which follow, we find that, under the unambiguous [*11] terms of the release between the parties, Mr. Task released all claims asserted herein, and we affirm the judgment of the trial court.

^{HN5}¶ A release ordinarily operates to extinguish a right in exchange for some consideration and effectively operates as an estoppel or a defense to an action by the releasor. As such, it is a contract between parties, enforceable at law subject to the rules governing the construction of contracts. Kelly v. Med. Life Ins. Co. (1987), 31 Ohio St.3d 130. Whether a release operates upon a certain liability depends entirely upon the intention of the parties,

which is to be gathered from the language of the release and the state of facts then existing. Whitt v. Hutchison (1975), 43 Ohio St.2d 53, 330 N.E.2d 678; Kelly v. Med. Life Ins. Co., supra, paragraph one of the syllabus; Shifrin v. Forest City Ent., Inc. (1992), 64 Ohio St.3d 635. If the parties to a release intend to leave some things out of a release, then "their intent to do so should be made manifest." United States v. William Cramp & Sons Ship & Engine Bldg. Co. (1907), 206 U.S. 118, 51 L. Ed. 983, 27 S. Ct. 676. When the terms of a contract are unambiguous, courts will not, [*12] in effect, create a new contract by finding an intent not expressed in the language employed by the parties. Alexander v. Buckeye Pipe Line Co. (1978), 53 Ohio St. 2d 241; Whitt v. Hutchison, supra. Moreover, when the parties have negotiated the release with the assistance of legal counsel, and both sides have agreed to the language included in the release, there is an assumption that the parties are fully aware of the terms and scope of their agreement. See Scott v. River Terminal Railway Co. (May 13, 1976), Cuyahoga App. No. 34892, unreported.

This court is further mindful that ^{HN6} where general words alone are used in the release, they are to be construed most strongly against the releasor. Id.; Shaker v. Phillips (1978), 54 Ohio Misc. 21, 376 N.E.2d 983. When, however, the terms of a release are so general as to include within its terms claims to which the releasing party was ignorant, and thus not within the contemplation of the parties when the release was executed, the release is voidable at the option of either party. See Sloan v. Standard Oil Co. (1964), 177 Ohio St. 149, 203 N.E.2d 237.

We turn now to the specific language of the release at issue in this [*13] appeal to determine whether it operates to bar Mr. Task from recovering for the claims set forth in his amended complaint. The language of the release clearly indicates the parties' intent to settle a wide variety of disputes arising out of National City's banking relationship with Mr. Task and/or Suburban. The release provided that the Tasks "hereby release and forever discharge [National City] * * * from any claims, demands, actions and/or causes of action, of any kind or description whatsoever, whether arising out of contract, tort, or otherwise, in law or in equity, which the Tasks or Suburban have, or have had against [National City] * * * ." (Emphasis added.) Giving this term of the release its ordinary meaning, the release indicates, unambiguously, the intent of the parties to release all of Mr. Task's claims against National City at issue herein.

Prior to entering into the settlement and release agreement, Mr. Task, alone, knew the facts of his banking relationship with National City. Had Mr. Task suspected wrongdoing on the part of National City, it was incumbent upon him to ascertain, at that time, whether he had a cause of action against National City on those facts [*14] and, if so, to expressly manifest his intent to exclude those claims from the scope of the release. Absent such an express exclusion in the release, it is the judgment of this court that the language of the release is broad enough to include the claims at issue herein.

The record similarly does not support Mr. Task's contention that he lacked knowledge of his claims for breach of contract, tortious interference, lender liability and conversion of funds at the time he signed the release and that such ignorance on his part constitutes a "mistake" that precludes application of the release in this case.

Appellant bases his argument upon the Ohio Supreme Court's holding in Sloan v. Standard Oil Co. (1964) 177 Ohio St. 149, 203 N.E.2d 237, wherein the court held that ^{HN7} a release may be avoided where the releasor can establish by clear and convincing evidence that it was executed by mutual mistake, as between himself and the releasee, of a past or present fact, material to the release, unless it appears that the parties intended that all claims be relinquished.

National City, on the other hand, argues that it was not mistaken as to the scope of the release and that a unilateral misinterpretation [*15] of the legal effect of the release does

not preclude application of the release to bar Mr. Task's claims in this case. Since National City contends that there is no evidence of a mutual mistake and Mr. Task would bear the burden of production on this issue at trial, he was required to produce supporting evidence in his summary judgment response to substantiate that a genuine issue of material fact on this issue remains for trial. Wing v. Anchor Media, Ltd. of Texas (1991), 59 Ohio St.3d 108, 570 N.E.2d 1095.

Our review of the record reveals that Mr. Task raises no allegations of any conduct on the part of National City, nor is any evidence apparent from the record that could be construed as raising a question of material fact on the issue of mutual mistake by the parties in entering into the release. Mr. Task's lack of diligence in ascertaining whether he had other claims and his consequent lack of knowledge of his rights and the legal effect of the scope of the release are not grounds to relieve him of the effect of the release.

Moreover, the only evidence offered by Mr. Task attempting to show fraudulent conduct on the part of National City was his own affidavit stating that, [*16] had National City intended to include unknown claims, it would have indicated that intent specifically in the release. Such an accusation is, as a matter of law, insufficient to raise a genuine issue of material fact on the question of whether National City fraudulently induced Mr. Task into signing the release. See Haller v. Borrer Corp. (1990), 50 Ohio St.3d 10, 552 N.E.2d 207. Absent evidence of conduct on the part of National City or its attorney that misled Mr. Task into believing he had no claims, Mr. Task has failed to refute National City's contention that no genuine issue of material fact exists on the issue of fraudulent inducement. *Id.*

Accordingly, for the reasons set forth above, the court's order entering summary judgment in favor of National City should stand, and we affirm the judgment of the trial court.

This cause is affirmed.

It is ordered that appellees recover of appellants their costs herein taxed.

The Court finds there were reasonable grounds for this appeal. It is ordered that a special mandate issue out of this Court directing the Cuyahoga County Court of Common Pleas to carry this judgment into execution.

A certified copy of this entry shall constitute [*17] the mandate pursuant to Rule 27 of the Rules of Appellate Procedure.

SARA J. HARPER, PRESIDING JUDGE

BLANCHE KRUPANSKY, JUDGE

DONALD C. NUGENT, JUDGE

N.B. This entry is made pursuant to the third sentence of Rule 22(D), Ohio Rules of Appellate Procedure. This is an announcement of decision (see Rule 26). Ten (10) days from the date hereof, this document will be stamped to indicate journalization, at which time it will become the judgment and order of the Court and time period for review will begin to run.

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Citation: 1994 Ohio App. lexis 437

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Date/Time: Tuesday, November 20, 2007 - 11:11 AM EST

* Signal Legend:

Service: Get by LEXSEE®

Citation: 1996 Ohio App. Lexis 2313

*1996 Ohio App. LEXIS 2313, **

Richard E. Jacob, Plaintiff-Appellant, v. Grant Life Choices Fitness Center, Club Management, Inc., and Robert Getz, Defendants-Appellees.

No. 95APE12-1633

COURT OF APPEALS OF OHIO, TENTH APPELLATE DISTRICT, FRANKLIN COUNTY

1996 Ohio App. LEXIS 2313

June 4, 1996, Rendered

NOTICE:

[*1] THE LEXIS PAGINATION OF THIS DOCUMENT IS SUBJECT TO CHANGE PENDING RELEASE OF THE FINAL PUBLISHED VERSION.

PRIOR HISTORY: APPEAL from the Franklin County Court of Common Pleas.

DISPOSITION: Judgment affirmed.

CASE SUMMARY

PROCEDURAL POSTURE: Appellant member filed a negligence suit against appellees, fitness center, employee, and management company. The Franklin County Court of Common Pleas (Ohio) granted summary judgment to the fitness center, employee, and management company on the basis of an express release of liability signed by the member prior to joining the fitness center. The member appealed.

OVERVIEW: The member argued that the release was ambiguous and that the trial court erred in refusing to consider extrinsic evidence of his intent to assume the risk. Further, the member argued that the release was too general to be meaningful or valid because it did not specify the conduct, acts, or risk released. The court rejected the arguments of the member. The court held that the member had expressly agreed to release the fitness center, employee, and management company from liability for acts of active or passive negligence. The court ruled that the clause was unambiguous because it included the words release and negligence, and clearly specified the kind of liability released. Additionally, the release clearly specifies those persons released from liability. Pursuant to the terms of the release, the member agreed to release the fitness center, as well as its owners, officers, employees, agents, successors, and assigns who were not parties to the contract. The court concluded that the terms sufficiently identified the management company as an intended third-party beneficiary. Reasonable minds could only conclude that the member intended to release his negligence claims.

OUTCOME: The court affirmed the judgment.

CORE TERMS: unambiguous, enforceable, successors, assigns, summary judgment, moving party, beneficiary, non-moving, purported, genuine, negligence claims, passive negligence, causes of action, assignment of error, issue of material fact, specify, exercise program, guest, reasonable minds, intend, wanton, willful, personal injury action, damages resulting, informed consent, issue of intent, membership, deposition, agreeing, joining

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HN1 ↓ Summary judgment is appropriate only where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Ohio R. Civ. P. 56. It must appear from the evidence, when viewed in a light most favorable to the non-moving party, that reasonable minds can come to but one conclusion and that conclusion is adverse to the non-moving party. [More Like This Headnote](#)

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HN2 ↓ The moving party bears the initial responsibility of informing the trial court of the basis for the motion for summary judgment and identifying those portions of the record which demonstrate the absence of a genuine issue of fact on a material element of the non-moving party's claim. If the moving party satisfies its initial burden, the non-moving party has a reciprocal burden, outlined in Ohio R. Civ. P. 56(E), to respond to the moving party's allegations. [More Like This Headnote](#)

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HN3 ↓ Contract clauses, which relieve a party from its own negligence, are generally upheld in Ohio. In fact, a release of a cause of action for damages is ordinarily an absolute bar to a later action on any claim encompassed within the release. Such releases are valid in the context of recreational activities. Further, releases constitute an express assumption of risk. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN4 ↓ A party cannot be released from liability for its own wanton or willful conduct. Nor will a release be enforceable where it purports to release claims that were not within the contemplation of the parties when the release was signed. For this reason, the intent of the parties, with regard to exactly what kind of liability, as well as what persons and entities are being released, must be stated in clear and unambiguous terms. [More Like This Headnote](#) | [Shepardize: Restrict By Headnote](#)

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HN5 ↓ When the contract is clear and unambiguous, its interpretation and enforceability are questions of law, not fact, and intentions not expressed in the writing are

deemed to have no existence and may not be shown by parol evidence. [More Like This Headnote](#)

[Contracts Law](#) > [Third Parties](#) > [Beneficiaries](#) > [Types](#) > [Intended Beneficiaries](#) 
HN6 Contracts purporting to grant immunity from liability, or a limitation of liability, must be strictly construed and limited to intended beneficiaries. The third-party beneficiary need not be named in the contract as long as the third-party is contemplated by the parties and sufficiently identified. [More Like This Headnote](#)

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[Torts](#) > [Procedure](#) > [Settlements](#) > [Releases](#) > [General Overview](#) 
HN7 Contractual releases of liability are upheld where the releasor made a conscious decision to accept the consequences of the other person's negligence. [More Like This Headnote](#)

COUNSEL: Gerald J. Todaro Co., L.P.A., and Gerald J. Todaro, for appellant.

Earl, Warburton, Adams & Davis, Ted Earl, M. Dick Warburton, Jr., and Christopher R. Walsh, for appellees, Grant Medical Center and Grant Life Choices Fitness Center.

Jenks, Surdyk & Cowdrey, Robert F. Cowdrey and Jeffrey C. Turner, for appellees, Club Management, Inc., and Robert Getz.

JUDGES: CLOSE, J. BOWMAN and TYACK, JJ., concur.

OPINION BY: CLOSE

OPINION

(REGULAR CALENDAR)

OPINION

CLOSE, J.

This is an appeal of a summary judgment rendered in a personal injury action in favor of defendants-appellees, Grant Life Choices Fitness Center ("Fitness Center"), Club Management, Inc. ("CMI"), and Robert Getz. Plaintiff-appellant, Richard E. Jacob, was a member of the Fitness Center, an exercise facility which was managed by CMI. Robert Getz was employed by CMI as program director for the Fitness Center.

The following events gave rise to this lawsuit. Appellant collapsed in the locker room following his workout at [*2] the Fitness Center. He received assistance from Getz and subsequently went home only to be admitted several hours later to Riverside Methodist Hospital for treatment of a heart attack. Thereafter, appellant brought this personal injury action alleging, in essence, that appellees negligently failed to provide for his health and safety in the use of their exercise facility. According to appellant, appellees should have sought immediate medical assistance and that the delay in medical treatment caused appellant to suffer damages.

Appellees moved for summary judgment based upon an express release of liability, which

appellant had signed prior to becoming a member of the Fitness Center. Upon joining the Fitness Center, appellant signed two forms, one of which was an application for membership. The application was entitled "Membership Agreement" and contained the following waiver of liability clause:

"Waiver of Claims

"It is expressly agreed that all use of the Center facilities and any transportation provided by the Center shall be undertaken by a member or guest at his/her sole risk, and the Center shall not be liable for any injuries or any damage to any member [*3] or guest, or the property of any member or guest, or be subject to any claim, demand, injury or damages whatsoever, including, without any limitation, those damages resulting from acts of active or passive negligence on the part of the Center, its officers or agents. The member, for himself/herself and on behalf of his/her executors, administrators, heirs, assigns and successors, does hereby expressly forever release and discharge the Center, its owners, officers, employees, agents, assigns and successors from all such claims, demands, injuries, damages, actions or causes of action. *** " [Emphasis added.]

The other form was entitled "Informed Consent for Exercise Participation," and expressly stated, in pertinent part:

"Also, in consideration for being allowed to participate in the GFC exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the GFC and its staff members conducting the exercise program from any and all claims, suits, losses, or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during, or arising in [*4] any way from, the exercise program."

In granting appellees' motions for summary judgment, the trial court found that appellant had expressly agreed to release appellees from liability for "acts of active or passive negligence." Based on this language, the court found the waiver expressed a clear and unambiguous intent by appellant to release appellees from liability for their negligence.

Appellant now appeals to this court and raises the following single assignment of error:

"The trial court erred in its decision that no genuine issue of material fact exists on the intent of the Appellant to agree to an express assumption of the risk of Appellees' negligence."

HN1 Summary judgment is appropriate only where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Civ.R. 56. It must appear from the evidence, when viewed in a light most favorable to the non-moving party, that reasonable minds can come to but one conclusion and that conclusion is adverse to the non-moving party. Temple v. Wean United, Inc. (1977), 50 Ohio St. 2d 317, 364 N.E.2d 267.

HN2 The moving party bears the initial responsibility of informing [*5] the trial court of the basis for the motion and identifying those portions of the record which demonstrate the absence of a genuine issue of fact on a material element of the non-moving party's claim. Dresher v. Burt (1996), 75 Ohio St. 3d 280, 296. If the moving party satisfies its initial burden, the non-moving party has a reciprocal burden, outlined in Civ.R. 56(E), to respond to the moving party's allegations. Id., at 293.

The facts are not in dispute here. Rather, the issue centers around the impact of the release which appellant signed upon joining the Fitness Center and whether the release bars appellant's negligence claims. Appellant alleges that the release was ambiguous and that the trial court erred in refusing to consider extrinsic evidence of his intent to assume the risk of this injury and in refusing to submit the issue of intent to the jury.

We note initially that ^{HN3} contract clauses, which relieve a party from its own negligence, are generally upheld in Ohio. In fact, a "release of a cause of action for damages is ordinarily an absolute bar to a later action on any claim encompassed within the release." Haller v. Borror Corp. (1990), 50 Ohio St. 3d 10, [*6] 13, 552 N.E.2d 207; see, also, Willis v. Avery Label Sys., 1996 Ohio App. LEXIS 1057, (Mar. 21, 1996), Cuyahoga App. No. 68617, unreported. As relevant here, such releases are valid in the context of recreational activities. Thompson v. Otterbein College, 1996 Ohio App. LEXIS 389, (Feb. 6, 1996), Franklin App. No. 95APE08-1009, unreported (1996 Opinions 358, 366); Bowen v. Kil-Kare, Inc. (1992), 63 Ohio St. 3d 84, 90, 585 N.E.2d 384; Willis; Cain v. Cleveland Parachute Training Center (1983), 9 Ohio App. 3d 27, 457 N.E.2d 1185. Further, releases constitute an express assumption of risk. Anderson v. Ceccardi (1983), 6 Ohio St. 3d 110, 114, 451 N.E.2d 780.

To be enforceable, however, the release must be expressed in terms that are clear and unequivocal. Thompson, at 366. This is because intent is presumed to reside in the language the parties chose to employ in the agreement, and the intention of the parties governs the interpretation of releases. See Kelly v. Medical Life Ins. Co. (1987), 31 Ohio St. 3d 130, 509 N.E.2d 411, paragraph one of the syllabus; Whitt v. Hutchison (1975), 43 Ohio St. 2d 53, 58, 330 N.E.2d 678. When a contract is unambiguous, [*7] a court cannot in effect create a new contract by finding an intent not expressed in the clear language employed by the parties. Alexander v. Buckeye Pipe Line 7 Co. (1978), 53 Ohio St. 2d 241, 246, 374 N.E.2d 146. As more fully explained below, we conclude that the release was unambiguous and that appellant cannot now claim an intent different than that clearly stated in the release.

Appellant argues that the release was too general to be meaningful or valid because it did not "specify the conduct, acts or risk" released. Consequently, appellant claims there exists a genuine issue of material fact regarding his intent. Appellant asserts that he did not intend to release appellees from "any negligence" and that public policy and the rule of strict construction require greater specificity than "active or passive negligence." As support for his arguments, appellant relies on this court's decision in Thompson, as well as the Lorain County court's decision in Tanker v. N. Crest Equestrian Ctr. (1993), 86 Ohio App. 3d 522, 621 N.E.2d 589, and the Hamilton County court's decision in Holmes v. Health & Tennis Corp. of Am. (1995), 103 Ohio App. 3d 364, 659 N.E.2d 812. [*8]

The above decisions are all distinguishable from the facts of this case. In both Tanker and Holmes, the purported releases did not even contain the term "release." The waiver and release provision in Holmes stated:

"Use of our facilities is at your own risk, and we shall not be liable for any injury or damages resulting from your use of our services and facilities. *** "

The Holmes court held that, absent unambiguous language releasing a defendant from negligence claims, the purported release could not withstand summary judgment and the issue of intent must be presented to the jury. Similarly, the plaintiff in Tanker signed a contract agreeing to "assume full responsibility and liability for any and all *** personal injury *** ." The Tanker court found this language too general to be enforceable because it purported to cause plaintiff to assume full responsibility for anything that may happen to plaintiff, herself, or, for that matter, anyone else.

This court found the release in *Thompson* was too general to be enforceable because it purported to "release essentially everyone, including non-owners and non-employees, from any type [*9] of misconduct, whether it be negligent, wanton or willful conduct." *Id.*, at 368. [Emphasis *sic.*] The contract language in *Thompson* released "all other participants" from "all claims." ^{HN4} A party cannot be released from liability for its own wanton or willful conduct. *Bowen*, at 90. Nor will a release be enforceable where it purports to release claims which were not within the contemplation of the parties when the release was signed. *Tanker*, at 526. For this reason, the intent of the parties, with regard to exactly what kind of liability, as well as what persons and/or entities are being released, must be stated in clear and unambiguous terms. *Thompson*, at 368.

Unlike the above cases, the contract here clearly releases each appellee from liability for appellant's negligence claims. The clause includes the words "release" and "negligence." Thus, it clearly specifies the kind of liability released. Additionally, the release clearly specifies those persons released from liability by stating that "the Center, its owners, officers, employees, agents, assigns and successors" are "expressly forever released and discharged." Appellant cannot now assert that he was unaware [*10] that he would be precluded from suing appellees for any alleged negligence on their part.

Appellant's affidavit averring that he did not intend to release appellees from the results of any alleged negligence does not create a question of fact for the jury. ^{HN5} When the contract is clear and unambiguous, its interpretation and enforceability are questions of law, not fact, and "intentions not expressed in the writing are deemed to have no existence and may not be shown by parol evidence." *Alexander*, at paragraph one of the syllabus; see, also, *State Farm Fire & Casualty Co. v. Scandinavian Health Spa, Inc.*, 104 Ohio App. 3d 582, 662 N.E.2d 890, (June 21, 1995); *Aultman Hosp. Assn. v. Community Mut. Ins. Co.* (1989), 46 Ohio St. 3d 51, 53, 544 N.E.2d 920.

A complication arises with respect to CMI, however, because CMI was not an agent for the Fitness Center at the time appellant signed the release. As noted above, the overriding consideration and, thus, the determining factor, is the intent of the parties to the contract. *Willis*; Farnsworth, *Contracts* (1982) 715-721, Sections 10.2 and 10.3. ^{HN6} Contracts purporting to grant immunity from liability, or a limitation of liability, [*11] must be strictly construed and limited to intended beneficiaries. *Robert C. Herd & Co., Inc. v. Krawill Machinery Corp.* (1959), 359 U.S. 297, 3 L. Ed. 2d 820, 79 S. Ct. 766. The third-party beneficiary need not be named in the contract as long as the third-party is contemplated by the parties and sufficiently identified. *Chitlik v. Allstate Ins. Co.* (1973), 34 Ohio App. 2d 193, 299 N.E.2d 295.

Pursuant to the terms of the release, appellant agreed to release the Fitness Center, as well as "its owners, officers, employees, agents, successors and assigns" who were not parties to the contract. We conclude that these terms sufficiently identify CMI as an intended third-party beneficiary. The terms do not restrict "agents" to present or then-existing agents and do not prohibit future or subsequent agents. Since "intentions not expressed in the writing are deemed to have no existence," we conclude that CMI is an intended beneficiary of the release executed by appellant and the Fitness Center. *Aultman Hosp. Assn.*, at 53; *Willis*; *Griggy v. Edwards Motors, Inc.*, 1992 Ohio App. LEXIS 1302, (Mar. 11, 1992), Licking App. No. CA-3684, unreported; *Rohrbacher v. Citizens [*12] Bldg. Assoc.* (1941), 35 Ohio L. Abs. 226, 40 N.E.2d 157. Use of the terms "successors" and "assigns" also indicate that future third-parties were contemplated at the time the parties executed the release. Thus, appellant is precluded from suing CMI for any negligence as well.

Appellant argues that the release constitutes an invalid form contract because appellant did not have a meaningful opportunity to negotiate the terms of the release. Appellees claim this argument lacks merit because appellant testified in his deposition that he was able to read

and write, and because appellant voluntarily joined the Fitness Center aware of, and in exchange for, this release of liability.

The dispositive issue is whether appellant intended to release appellees. ^{HN7} Contractual releases of liability are upheld where the releasor made a conscious decision to accept the consequences of the other person's negligence. *Holmes, at 367; State Farm v Fire & Cas. Co.*

We hold that reasonable minds could only conclude that appellant intended to release his negligence claims. The release was captioned in bold type, "**Waiver of Claims.**" Furthermore, appellant signed a separate document expressly [*13] agreeing to assume the risk of his own injuries from participating in the Fitness Center's exercise program. Appellant testified in his deposition that he had an opportunity to read the release and informed consent document. He also testified that he was not under any mental disability. There are no allegations and no proof of fraud. Thus, appellant has not demonstrated that the release was anything other than consciously made.

Appellant's assignment of error is overruled.

For the above reasons, we conclude that the release is valid and enforceable. The summary judgment is affirmed in all respects. Appellant's sole assignment of error is overruled and the judgment of the trial court is affirmed.

Judgment affirmed.

BOWMAN and TYACK, JJ., concur.

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