Ohio | Bureau of Workers' Compensation

Application for Ohio Workers' Compensation Coverage

Have questions? Need assistance? BWC is here to help!
Call 1-800-644-6292, and listen to the options to reach a customer service representative.
You can dial the number nationwide, and in Canada and Mexico from 7:30 a.m. to 5:30 p.m. EST.
Remember, you can access information and request services by visiting BWC's Web site at www.bwc.ohio.gov.

BWC will not process incomplete applications. All required fields (*) must be completed.
BWC will also not process applications without a $120 non-refundable application fee.

General information - completed by all employer types

*Legal business name or homeowner	Trade name or doing business as name
*Date employees first earned wages in Ohio. If no employees, enter today's date.	*Federal employer identification number or Social Security number

***Primary physical (Ohio) location:** If no Ohio location, provide your out-of-state location (Attach additional locations, if applicable)

Street (Do not use P.O. box) | City | State | ZIP code

*Location phone	Location fax number
Email address	Website
*Contact name	*Contact phone
Mailing address: If different from primary physical (Ohio) location Street	City
State, ZIP code	Mailing address phone
Mailing address fax number	Email address
Contact name	Contact phone

Business entity information

☐ Domestic household: Applies to full/part-time domestic workers employed inside or outside your private residence.
Check the type of services your domestic household employees will perform within your residence.
☐ Domestic inside and/or outside yard/ground maintenance ☐ Home improvement/Maintenance ☐ Construction (new/addition/roofing) on or in your home.
12-month payroll estimate _____

*Please check the one business entity type below that applies to you.

☐ Sole proprietor	☐ Limited liability company acting as a sole proprietor	☐ Corporation
☐ Partnership	☐ Limited liability company acting as a partnership	☐ Individual incorporated as a corporation
☐ Limited partnership	☐ Limited liability company acting as a corporation	☐ Family farm corporation

Incorporation date	Charter number	State where incorporated

Business purchase/Associated policy information

*Have there been other Ohio workers' compensation policies associated with this operation or any other affiliated operation? ☐ Yes ☐ No

*Do any of the principals have workers' compensation coverage in this or any other operation; or have they had workers' compensation coverage in any operation in the past? ☐ Yes ☐ No

List policy(s)#_____ Name _____

*Did you acquire/purchase this business? ☐ Yes ☐ No	*Previous owner's name and BWC policy number	*Date you acquired/purchased business	*Did you acquire/purchase ☐ all or ☐ part of an existing business

Previous employer contact name	Previous employer phone number

*Do you have a purchase agreement associated with the transaction? ☐ Yes ☐ No
If yes, BWC may request a copy of the agreement.

Has the business been in continuous operation? ☐ Yes ☐ No
Explain

Did you acquire or purchase the former employer's contracts or customers? ☐ Yes ☐ No
Explain

Are you operating in the former employer's location? ☐ Yes ☐ No
Explain

Will you conduct business in the same/similar manner as the former employer? ☐ Yes ☐ No
Explain

How many employees of the former employer did you hire? _____

Did you acquire or purchase any machinery or equipment from the former employer? ☐ Yes ☐ No
Explain

Elective coverage

See additional details in the business entity information and elective coverage sections for completing the application, which describe the reporting requirements for elective coverage.

Coverage on the owners or officers of a corporation and a limited liability company acting as a corporation (except for individuals incorporated as a corporation with no employees) is not voluntary.

However, coverage on certain owners or ministers is voluntary. Listed below are the categories of individuals that qualify for elective coverage.

- Sole proprietor
- Partnership
- Limited liability company acting as a sole proprietor
- Limited liability company acting as a partnership
- Family farm corporate officers
- Ordained or associate minister of a religious organization
- Individual incorporated as a corporation (with no employees)

If someone at your company meets the qualifications for elective coverage, please enter all of their names in the owner/officers/minister information section. If you select yes to request elective coverage, please understand that by electing coverage that you are acknowledging your agreement to the minimum payroll reporting requirements outlined in the U-3 instructions. Remember, if you choose not to cover yourself and you are injured at work, BWC will not provide coverage, and other insurance may not cover your work-related disability or medical bills.

☐ Please initial to acknowledge you have read and understand the elective coverage guidelines.

Owners/officers/ministers information – Please provide the required information for all owners and officers. If you are a religious organization and wish to elect coverage on your ministers, you must also provide this information for the ministers.

*Name #1 (last, first, middle) | *% Ownership

*Home address (street or PO Box)

*City | *State | *ZIP code

*Social Security number | *Title | Phone

*For individuals that qualify, do you wish to elect coverage?
☐ Yes I do wish to elect coverage for myself.
☐ No I understand that BWC will not pay benefits for my work-related injury if I do not elect coverage.

*Name #2 (last, first, middle) | *% Ownership

*Home address (street or PO Box)

*City | *State | *ZIP code

*Social Security number | *Title | Phone

*For individuals that qualify, do you wish to elect coverage?
☐ Yes I do wish to elect coverage for myself.
☐ No I understand that BWC will not pay benefits for my work-related injury if I do not elect coverage.

*Name #3 (last, first, middle) | *% Ownership

*Home address (street or PO Box)

*City | *State | *ZIP code

*Social Security number | *Title | Phone

*For individuals that qualify, do you wish to elect coverage?
☐ Yes I do wish to elect coverage for myself.
☐ No I understand that BWC will not pay benefits for my work-related injury if I do not elect coverage.

***Total ownership %**

Out-of-state considerations

Are you an Ohio employer with employees working outside Ohio? ☐ Yes ☐ No

Are your employees covered under another workers' compensation policy issued for a state other than Ohio? ☐ Yes If yes, provide the information below.
☐ No

Insurer name: _____ Policy number: _____

Was the contract of hire for your employees entered into: Select one ☐ Exclusively in Ohio ☐ Exclusively in a state other than Ohio
☐ Combination of Ohio and in a state other than Ohio

Operations description

*Check all types that apply to your Ohio operations.

Agriculture ☐ Crop ☐ Livestock ☐ Dairy ☐ Vegetable ☐ Poultry ☐ Orchard ☐ Berry/vineyard

Extraction ☐ Mining ☐ Oil or gas ☐ Quarry

Construction ☐ Permanent yard operations ☐ Residential three stories and under ☐ Interior trim/cabinets
☐ Commercial, industrial and dwellings more than three stories
☐ Other (describe)_____

Transportation ☐ Owned goods ☐ Non-owned goods ☐ Ground ☐ Air carrier ☐ Water transport ☐ Interstate carrier
☐ Gen. Freight ☐ Parcel ☐ People ☐ Appliance ☐ Furniture ☐ Oil ☐ Gas
Distance ☐ Local 200 miles or less ☐ More than 200 miles

Commercial (merchandising) ☐ Wholesale: Sales_____% ☐ Retail: Sales_____% ☐ Packaging ☐ Drivers/delivery
☐ Repair ☐ Principal products sold_____
☐ Coffee or tea house (no cooking) ☐ Beverages_____% of total sales ☐ Food _____% of total sales

Service ☐ Restaurant – fast food ☐ Restaurant – wait service (not counter) ☐ Delivery
☐ Alcohol ____% of receipts compared to total sales
☐ Warehousing for others ☐ Religious organization ☐ Residential house cleaning ☐ Commercial cleaning
☐ Vacant residential cleaning ☐ Domestic employees working in your home

☐ Elevated Cleaning from Stool, ladder etc.

Office work/ ☐ Medical office ☐ Attorney ☐ Real estate agent ☐ Property management (not property preservation)

*Describe your services or products, including your methods of operations. Include raw and semi-finished materials used (attach additional documentation, if necessary). Note: It is important for you to provide as much information as possible for BWC to properly determine your correct classification.

_____

_____

_____

_____

*Describe machinery, equipment and tools (attach additional documentation, if necessary).

_____

_____

_____

_____

*If you do not have a primary physical Ohio location, provide an explanation for not having an Ohio location and/or reason you are applying for Ohio coverage.

_____

_____

_____

_____

Payroll by operation type

*List all types of operations that apply (attach additional sheets if necessary).	*For each operation type, estimate total number of employees.	*For each operation type, estimate total payroll for next 12 months.
The following are in addition to the above: **Clerical** ☐ Office personnel (no duties outside of the office, no counter service); ☐ Telecommuter (clerical employees working from residence);		
Traveling salespeople (no handling, servicing or delivery);		
Drivers (truck or delivery);		
Sole proprietors, partners or ministers (if elective-coverage is elected).		

Premium payment installment plan

Select the installment option that you will use for the next full policy year. For partial policy years, not starting on July 1, BWC will match as closely as possible to your selection.

☐ Annual (1) ☐ Semiannual (2) ☐ Quarterly (4) ☐ Bimonthly (6) ☐ Monthly (12)

Certification – signature required

Name (please print)_____

By my signature, I certify I have the authority to execute this application, and that the facts set forth on this application are true and correct to the best of my knowledge and belief. I am aware that any person who does not secure or maintain workers' compensation coverage and pay all appropriate premiums in accordance with Ohio laws, or misrepresents, conceals facts, or makes false statements to obtain coverage may be subject to civil, criminal and/or administrative penalties.

*Employer signature_____ *Date_____

WARNING: Insurance is not in effect until BWC receives the application and the $120 non-refundable application fee. BWC cannot process incomplete applications or applications submitted without payment.

You may submit your application online and pay your $120 non-refundable application fee using a checking or savings account, or a credit card (Master Card®, Visa® or American Express®) at www.bwc.ohio.gov. You may also submit the completed U-3 along with a $120 check or money order to:

Ohio Bureau of Workers' Compensation
P.O. Box 15698
Columbus, OH 43215-0698

BWC USE ONLY

Policy number	Application number	Effective date	Payment type ☐ Cash ☐ Check	Payment amount	Date received	Initials