Application for

Ohio Workers' Compensation Coverage

Have questions? Need assistance? BWC is here to help!
Call 1-800-OHIOBWC, 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 ohiobwc.com

BWC will not process incomplete applications.

General information - completed by all employer types

Legal business name or homeowner	Trade name or doing business as name
Date one or more employees hired in Ohio	Federal employer identification number or Social Security number

Primary physical location: List additional locations on additional sheets if necessary

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

Contact name	Telephone number ( )	Fax number ( )
E-mail address	Web site	

Mailing address: If different from primary physical location

Street	City	State	ZIP code

Business entity information

☐ Domestic household (applies to domestic workers employed inside and outside a 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)

Eight-month payroll estimate ________

STOP! You have completed the application for domestic coverage. Please sign the application, and return this form to BWC along with your $10 minimum security deposit.

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

☐ Sole proprietor
☐ Partnership
☐ Limited partnership
☐ Limited liability company acting as a sole proprietor
☐ Limited liability company acting as a partnership
☐ Limited liability company acting as a corporation
☐ Corporation
☐ Individual incorporated 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?
☐ Yes ☐ No If yes, list the policy number(s) and/or business name below; use additional sheets if necessary.

List policy(s)#________________ name________________

☐ Yes ☐ No Has the ownership of this operation changed?
☐ Yes ☐ No Has the federal ID number or SSN changed?

Did you purchase this business? ☐ Yes ☐ No	Previous owner's name and BWC policy number	Date you purchased business	Did you purchase ☐ **All** or ☐ **Part** of business?

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

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, do you wish to elect coverage?

☐ Yes Important – Indicate which individuals you wish to cover in the Owners/Officers/Ministers information section of this application. By electing coverage you are acknowledging your agreement to the minimum payroll reporting outlined in the instruction sheet.

☐ No I understand I elected to NOT cover any individuals at my company that qualify for elective coverage. 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.
Initials: ___________

Owners/Officers/Ministers information – You must list all owners/officers, and any ministers you elect to cover under the religious organization's policy. (Attach additional sheets, if necessary.)

Name #1 (Last, First, Middle)			% Ownership
Home address (street or PO Box)			
City	State	ZIP code	
Social Security number	Title		
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		
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		
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 % ______

Operations description

Check all types that apply to your Ohio operations.

Agriculture ☐ Crop ☐ Livestock ☐ Dairy ☐ Vegetable ☐ Poultry ☐ Orchard ☐ Berry/Vineyard ☐ Other

Extraction ☐ Mining ☐ Oil or Gas ☐ Quarry ☐ Other

Manufacturing ☐ All types, including assembly or shop repair

Construction ☐ General contractor ☐ Subcontractor ☐ Permanent yard operations ☐ Residential three stories and under
☐ Apartments/Condos ☐ Commercial, industrial and dwellings more than three stories
Type of material used ☐ Steel ☐ Concrete ☐ Wood ☐ Masonry
☐ Other (describe)____

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

Utility ☐ Gas ☐ Oil ☐ Electric ☐ Phone ☐ Cable ☐ Water ☐ Sewer

Commercial (Merchandising) ☐ Wholesale: Sales_____% ☐ Retail: Sales_____% ☐ Packaging ☐ Drivers/Delivery
☐ Repair ☐ Principal products sold_____________ ☐ Other

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 ☐ Other

High risk Commercial/Service ☐ Explosive ☐ Police/Security ☐ Fire/EMS ☐ Atomic/Nuclear ☐ Other

Office work/ Miscellaneous ☐ Medical office ☐ Attorney ☐ Property management ☐ Professional employer organization (PEO)
☐ Temp. agency ☐ Consulting (Please explain under Operation Description.) ☐ Other

Describe your primary 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.

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

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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 eight 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 self-coverage is elected).		

Certification – signature required

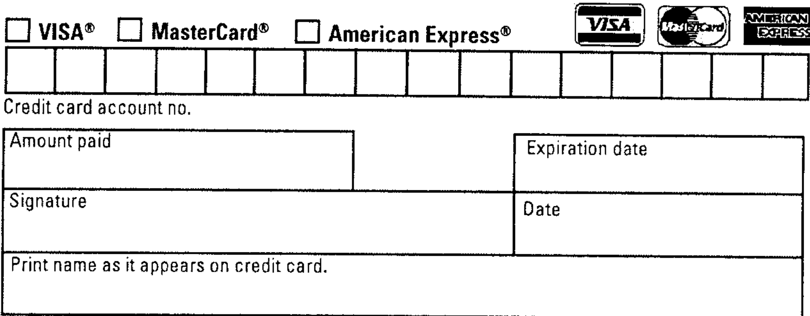
Name (please print) ______________________________

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 $10 security deposit.
BWC will bill the balance of the security deposit.
BWC will not process incomplete applications.

You also may pay by check or money order.
Mail completed form and
$10 security deposit to:
Ohio Bureau of Workers' Compensation
P.O. Box 15698
Columbus, OH 43215-0698



Credit card payment information

☐ **VISA®** ☐ **MasterCard®** ☐ **American Express®**

Credit card account no.

Amount paid	Expiration date
Signature	Date
Print name as it appears on credit card.	

BWC USE ONLY

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