



- The employer or the employer's representative uses this form to request a decision by the Adjudicating Committee to settle the employer's non-compliance liability to the state insurance fund.
The employer must sign and have this request notarized.
Attach current financial information (a copy of the past three years, federal and state income tax returns) to this application.
Mail completed, signed and notarized form to: BWC, Legal Operations, Settlement Unit, P.O. Box 15398, Columbus, OH 43215-0398, or send a fax to 614-719-5941. Please call 614-752-9040 with questions.

Employer name, Policy number, Employer Contact name, Telephone number, Fax number, Street address, E-mail address, City, State, ZIP code, Injured worker name, Claim number(s), Street address, City, State, ZIP code

1. State reasons why a settlement would be in the best interest of both the applicant and the State of Ohio.
2. Number of employees hired by applicant:
3. Location of employer business:
4. Length of time employer has been in business:
5. Nature and type of employer business:
6. Please explain why the employer did not have workers' compensation coverage when the injured worker was injured.
7. Dollar amount employer proposes to pay for settlement: \$
Note: Payment arrangements may be requested.
8. Is the employer presently carrying workers' compensation coverage? Yes No If no, please state the reason why.
9. Additional information you feel is relevant to your request:
Attachments (please list):

The information contained in said application is true to the best of my knowledge.

Sworn to before me and signed in my presence this day of , .

Officer's signature

Title Date

Notary Public, State of