



Bureau of Workers' Compensation

30 W. Spring St.
Columbus, OH 43215-2256

Dear Self-insured Applicant:

Self-insuring employers may elect not to participate in the handicap reimbursement program.

Employers remaining in the program will not receive more in handicap reimbursement than its paid assessment for handicap reimbursement in any given year.

If your company elects to withdraw from this program, the election becomes effective in the billing period following completion and receipt of this form in our office. In the case of new applicants, the election becomes effective upon approval of self insurance.

If you wish to withdraw from the handicap reimbursement program, please complete the bottom portion of this letter and return it to the self-insured section.

This election is irrevocable.

Risk No.

I hereby elect to withdraw from the handicap reimbursement program effective _____ .

I certify I am empowered to make this election on behalf of _____ , a self-insured employer.

| | |
|-----------|------|
| Signature | |
| Title | Date |

Return This Form To:

**Self-insured Section
P.O. Box 182334
Columbus, OH 43218-2334**