Ohio | Bureau of Workers' Compensation

Initial Application by Employer for Authority to Pay Compensation Etc., Directly

SIDN Application Number

Instructions
- Please answer **all** questions. If not applicable, use symbol N/A.
- Please use **SIDN** number for all correspondence and inquiries until assigned a self-insured risk number.
- File all requests for data and financial statements, or we will return your application as incomplete.
- You must file this form with: ATTN: Self-Insured Department, Bureau of Workers' Compensation, 30 W. Spring St., 27th Floor, Columbus, Ohio 43215-2256.

Company Information

Name of applicant (shown exactly as it is in the Articles of Incorporation)			Present state-fund risk number	Federal ID number
Address				
City	County	State		Nine digit ZIP code
Corporate contact persons				Corporate phone number ( )
Type of entity (check appropriate box) ☐ Corporation ☐ Association ☐ Partnership ☐ Sole Proprietor			State of incorporation	Date of incorporation

If applicant is a PARTNERSHIP, name all partners and designate whether they are general, special, limited, etc.

Name	Address	Designation

Complete this Section if Applicant is a Subsidiary

Name of ultimate USA parent (show exactly as it is in the Articles of Incorporation)			Ultimate USA parent federal ID number
State of incorporation	Date of incorporation	Percentage of ownership %	**Please attach a detailed organizational chart, if applicable**

Additional Applicant Information

How long have you been operating in Ohio under the state-fund risk number listed on the other side of this form? _____Years _____Months

Have you ever carried Ohio Workers' Compensation under any other risk number or name before? ☐Yes ☐No
If yes, please complete information below.

Company name		
Risk number	Did you purchase ☐ All ☐ Part of business	Was business ☐ Operating ☐ Inactive at time of purchase

What is the nature of the business of the applicant employer, within the State of Ohio?

What was the date of commencement, or is the proposed date of commencing business in Ohio?

Please complete (Please note: You may obtain manual numbers and descriptions by reviewing your DP-21 Payroll Report(s) submitted to the Ohio State Insurance Fund.)

Manual number	Manual description	Number of Ohio employees

Financial Information

Please note: If the applicant does not possess the required financial information, the ultimate (USA) parent of the applicant must provide all required financial information. This information must include certified balance sheets and profit and loss statements (with footnotes). In addition, you must include 10-K and 10Q reports, if available, for the last five years. We also require current year unaudited balance sheet and profit and loss statements. Formal annual reports containing the above mentioned statements are acceptable.

Total Ohio assets at end of last fiscal year or calendar year	Total Ohio gross payroll for last calendar year or fiscal year

Excess Workers' Compensation Insurance

Does your company intend to carry excess workers' compensation insurance? ☐Yes ☐No

Name of carrier: _____

Name of agent: _____ Telephone number: (_____) _____

Policy number: _____

Limit of indemnity: _____

Self-insured retention: _____

Certification

State_____ County of _____

being duly sworn says that he/she is the _____ (Title)

of _____ , the employer referred to in the foregoing statements and that all of the foregoing statements are true to the best of his/her knowledge, information and belief after careful investigation.

Sworn to me, this _____ day of _____, _____ .

_____ (Notary seal)

_____ (Corporate officer)

Instructions
- List the location that will complete the DP-2 Payroll Report.
- List all payroll centers. A payroll center is a location that collects payroll information and which reports to the location listed in number one.
- List all locations that administer the claims and maintain files for audit purposes.

Information Update Request

Self-insured risk number: ____________

Company: ____________

This form completed by:

Name and title	Area code and telephone number

______ Hourly employees

______ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________

DBA/Division: ____________

Attention: ____________

Telephone number: ____________

Address: ____________

______ Hourly employees

______ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________

DBA/Division: ____________

Attention: ____________

Telephone number: ____________

Address: ____________

______ Hourly employees

______ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________

DBA/Division: ____________

Attention: ____________

Telephone number: ____________

Address: ____________

Additional locations on reverse side.

Important notice: When filing claims, use the division codes that have been assigned to your various locations.

_________ Hourly employees

_________ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________________

DBA/Division: ____________________

Attention: ____________________

Telephone number: ____________________

Address: ____________________

_________ Hourly employees

_________ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________________

DBA/Division: ____________________

Attention: ____________________

Telephone number: ____________________

Address: ____________________

_________ Hourly employees

_________ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________________

DBA/Division: ____________________

Attention: ____________________

Telephone number: ____________________

Address: ____________________

_________ Hourly employees

_________ Salaried employees

2. Payroll center: ☐ Yes ☐ No

3. Claim files maintained: ☐ Yes ☐ No

BWC USE ONLY

Self-Insured risk number:

1. Company: ____________________

DBA/Division: ____________________

Attention: ____________________

Telephone number: ____________________

Address: ____________________