



Instructions

- Please answer **all** questions. If not applicable, use symbol N/A.
- File all requests for data and financial statements, or we will return your application as incomplete.
- Email the completed form to the self-insured inquiry email box, SIINQ@bwc.state.oh.us.

Company information			
Name of applicant (shown exactly as it is in the Articles of Incorporation)		Present state-fund policy number	Federal ID number
Address			
City	County	State	Nine digit ZIP code
Corporate contact persons			Contact phone number ()
Email address			
Type of entity (check appropriate box) <input type="checkbox"/> Association <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> 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-funded policy number listed on the other side of this form? _____ Years _____ Months

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

Company name _____

Policy number _____	Did you purchase <input type="checkbox"/> All <input type="checkbox"/> Part of business	Was business <i>at time of purchase</i> <input type="checkbox"/> Operating? <input type="checkbox"/> Inactive?
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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 annual 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 _____
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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)

Information Update Request

Instructions

- List all locations that administer the claims and maintain files for audit purposes.

Company: _____

This form completed by:

Name and title	Telephone number ()
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_____ Hourly employees

1. Company: _____

_____ Salaried employees

DBA/Division: _____

2. Claim files maintained: Yes No

Contact name: _____

Email: _____

Telephone number: _____

Address: _____

_____ Hourly employees

1. Company: _____

_____ Salaried employees

DBA/Division: _____

2. Claim files maintained: Yes No

Contact name: _____

Email: _____

Telephone number: _____

Address: _____

_____ Hourly employees

1. Company: _____

_____ Salaried employees

DBA/Division: _____

2. Claim files maintained: Yes No

Contact name: _____

Email: _____

Telephone number: _____

Address: _____
