Ohio | Bureau of Workers' Compensation

Application for Ohio Workers' Compensation Coverage

Have questions? Need assistance? BWC is here to help!
Call 1-800-644-6292, 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 www.bwc.ohio.gov.

BWC will not process incomplete applications. You must complete all required fields (*).
BWC will also not process applications without a $120 non-refundable application fee.

General information – completed by all employer types

*Legal business name or homeowner name	*Federal employer identification number or Social Security number
Trade name or doing business as name	*Date employees first earned wages in Ohio. If no employees, enter today's date.

Address information

*Primary physical (Ohio) location: If no Ohio location, provide your out-of-state location

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

*Mailing address: If different from primary (Ohio) location

Street | City | State | ZIP code

Additional Ohio locations (attach additional sheets if necessary)

Street, City, State, ZIP code	Brief description of operation

Business information (for your primary Ohio location)

*Business phone: Is this a cell ☐ Yes or ☐ No	Business fax
Business email	Business website

Business contact information (primary contact(s) for the business)

*Contact #1 (First, Middle initial, Last and Suffix)	*Title/Contact type
*Phone: ☐ Direct Dial or ☐ Cell	Email
Contact #2 (First, Middle Initial, Last and Suffix)	Title/Contact type
Phone: ☐ Direct Dial or ☐ Cell	Email

Domestic household coverage

☐ Domestic household: Applies to full/part-time domestic workers employed inside or outside your 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) on or in your home.

12-month payroll estimate _____

Business entity information

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

☐ Sole proprietor
☐ Partnership
☐ Limited partnership
☐ Corporation
☐ Limited liability company acting as a sole proprietor
☐ Limited liability company acting as a partnership
☐ Limited liability company acting as a corporation
☐ Individual incorporated as a corporation
☐ Family farm corporation
☐ Association
☐ State/local government

Incorporation date	Charter number	State where incorporated

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) are automatically covered (i.e., coverage is not voluntary).

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 individuals at your company meet the qualifications for elective coverage, please enter all of their names in the owner/officers/minister information section. If you select yes to request elective coverage, please understand that by electing coverage that you are acknowledging your agreement to the minimum payroll reporting requirements outlined in the U-3 instructions. 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.

☐ Please initial to acknowledge you have read and understand the elective coverage guidelines.

Owners/officers/ministers: Include the names of all owners and officers. If you are a religious organization you only need to provide the names of the ministers who you wish to elect coverage.

*Name #1 (First, Middle Initial, Last and Suffix)	*Social Security number	Date of birth	*Title/Relationship
*Home mailing address (street, city, state, ZIP code)			*% Ownership
*Phone: ☐ Home or ☐ Cell	Email		
*Duties			
*For individuals that qualify, do you wish to elect coverage? (see elective coverage section) ☐ 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 (First, Middle Initial, Last and Suffix)	*Social Security number	Date of birth	*Title/Relationship
*Home mailing address (street, city, state, ZIP code)			*% Ownership
*Phone: ☐ Home or ☐ Cell	Email		
*Duties			
*For individuals that qualify, do you wish to elect coverage? (see elective coverage section) ☐ 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 (First, Middle Initial, Last and Suffix)	*Social Security number	Date of birth	*Title/Relationship
*Home mailing address (street, city, state, ZIP code)			*% Ownership
*Phone: ☐ Home or ☐ Cell	Email		
*Duties			
*For individuals that qualify, do you wish to elect coverage? (see elective coverage section) ☐ 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
Extraction	☐ Mining	☐ Oil or gas	☐ Quarry				
Manufacturing	☐ Yes If yes, please complete the section of the application where you are to describe your service or products.						
Construction	☐ Permanent yard operations	☐ Residential three stories and under	☐ Interior trim/cabinets				
	☐ Commercial, industrial and dwellings more than three stories						
	☐ Other (describe) _____						
Transportation	☐ Owned goods	☐ Non-owned goods	☐ Ground	☐ Air carrier	☐ Water transport	☐ Interstate carrier	
	☐ Gen. freight	☐ Parcel	☐ People	☐ Appliance	☐ Furniture	☐ Oil	☐ Gas
	Distance	☐ Local 200 miles or less		☐ More than 200 miles			
Utility	☐ Yes If yes, please complete the section of the application where you are to describe your service or products.						
Commercial	☐ Wholesale: Sales_____%	☐ Retail: Sales _____%		☐ Packaging		☐ Drivers/delivery	
(merchandising)	☐ Repair	☐ Principal products sold _____					
	☐ Coffee or tea house (no cooking)	☐ Beverages _____% of total sales		☐ Food _____% of total sales			
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	☐ Domestic employees working in your home	☐ Elevated cleaning from stool, ladder etc.				
High risk Commercial/Service	☐ Yes If yes, please complete the section of the application where you are to describe your service or products.						
Office work/ Miscellaneous	☐ Clerical	☐ Outside sales	☐ Medical office	☐ Attorney	☐ Real estate agent		
	☐ Property management (not property preservation)	☐ Professional employee organization	☐ Temp. agency				

*Describe your 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.

_____

_____

_____

_____

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

_____

_____

_____

*If you do not have a primary physical Ohio location, provide an explanation for not having an Ohio location and/or reason you are applying for Ohio coverage.

_____

_____

_____

Out-of-state considerations

Ohio employers: Do you have employees who are supervised from Ohio but work within and outside of Ohio, or work temporarily outside Ohio? ☐ Yes ☐ No If yes, are the employees covered under another workers' compensation policy issued for a state other than Ohio? ☐ Yes ☐ No
*If yes, provide the insurance information below.

Insurer name: _____ Policy number: _____

Out-of-state employers: Do you have regular employees who are residents of a state other than Ohio that will perform work in Ohio for a temporary period not to exceed 90 days? ☐ Yes ☐ No *If yes, provide the insurance information below.

Insurer name: _____ Policy number: _____

Premium payment installment plan

Select the installment option that you will use for the next full policy year. For partial policy years, not starting on July 1, BWC will match as closely as possible to your selection.

☐ Annual (1) ☐ Semiannual (2) ☐ Quarterly (4) ☐ Bimonthly (6) ☐ Monthly (12)

Estimated annual payroll by operation type

*Operation type (List all types - attach additional sheets if necessary). Provide estimated information for all employees including officers of a corporation or LLC corporation	*Estimate number of employees.	*Estimate total payroll for next twelve months.
Clerical office personnel (No duties outside the office, in sales or service, no counter service or exposure to factory operations);		
Clerical telecommuter (clerical employees working from residence);		
Traveling salespeople (no handling, service or delivery);		
Drivers (truck or delivery).		
Provide estimated information for each sole proprietor, partner, individual incorporated as a corporation, family farm corporate officer or minister that has elected coverage on themselves.		
Name #1:		
Name #2:		
Name #3:		

Business acquisition/merger or purchase/sale and associated policy information

Have there been other Ohio workers' compensation policies associated with this operation or any other affiliated operation? ☐ Yes ☐ No

List policy(s) number _____

*Do any of the principals have workers' compensation coverage in this or any other operation; or have they had workers' compensation coverage in any operation in the past? ☐ Yes ☐ No

Name _____

*Did you acquire/purchase this business? ☐ Yes ☐ No	*Previous business name and BWC policy number	*Date you acquired/purchased business	*Did you acquire/purchase ☐ all or ☐ part of an existing business

Did you acquire/purchase this business from a family member? ☐ Yes ☐ No If yes, indicate relationship _____	Was this a stock acquisition? ☐ Yes ☐ No If yes, did you retain the previous employer's federal identification number? ☐ Yes ☐ No	How many employees of the former employer did you hire?

Previous employer contact name	Previous employer phone number	Do you have a purchase agreement associated with the transaction? ☐ Yes ☐ No If yes, BWC may request a copy of the agreement.

Was the business purchased out of bankruptcy or receivership? ☐ Yes ☐ No
Explain

Has the business been in continuous operation? ☐ Yes ☐ No
Explain

Did you acquire/purchase the previous employer's contracts or customers? ☐ Yes ☐ No
Explain

Are you operating in the former employer's location? ☐ Yes ☐ No
Explain

Will you conduct business in the same/similar manner as the former employer? ☐ Yes ☐ No
Explain

Did you acquire or purchase any machinery or equipment from the former employer? ☐ Yes ☐ No
Explain

Certifications – 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 _____ Title: _____ *Date: _____

WARNING: Insurance is not in effect until BWC receives the application and the $120 non-refundable application fee. In addition, coverage should be contingent on the timely receipt of the first installment payment.

BWC will bill the balance of the yearly premium. BWC cannot process incomplete applications or applications submitted without payment.

BWC USE ONLY

Policy number	Quote number	Effective date	Payment type ☐ Money order ☐ Check	Payment amount	Date received	Initials