

Application for

# Ohio Workers' Compensation Coverage

*Workers' compensation coverage – Protection with your business in mind*



**Have questions? Need assistance? We're here to help!**

**Call 1-800-OHIOBWC, and follow the prompts 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 BWC's Web site at [ohiobwc.com](http://ohiobwc.com)**

Workers' compensation coverage protects you and your employees in the event of a work-related injury, disease or death. In Ohio, all employers with one or more employees must carry workers' compensation coverage. It's the law. Coverage for Ohio employers and their employees (i.e., employees whose contracts of hire have been consummated within the borders of Ohio, whose employment involves activities both within and without the borders of Ohio and where the supervising office of the employer is located in Ohio), becomes effective when BWC receives this completed application. Independent contractors and subcontractors also must obtain coverage for their employees.

Officers of a corporation are considered employees for the purposes of workers' compensation; except for an individual incorporated as a corporation (to qualify must have a single/sole owner with no employees).

However, if you are self-employed, a partner in a business, an officer of a family farm corporation or an individual incorporated as a corporation, you are not automatically covered. You may elect coverage for yourself by selecting Yes in the Optional supplemental coverage section and Owners/Officers/Ministers information section of this application.

## **It's easy to obtain coverage following these steps:**

- ① Apply for coverage online at [ohiobwc.com](http://ohiobwc.com), or complete this application for coverage;
- ② Provide as many details as possible. When describing the nature of the business, include the type of work performed and the equipment used;
- ③ Sign and date the application. It's not valid without a signature;
- ④ Detach and mail the completed application with a \$10 minimum security deposit to:  
**Ohio Bureau of Workers' Compensation**  
**P.O. Box 15698**  
**Columbus, OH 43215-0698**

Please make check or money order payable to the **Ohio Bureau of Workers' Compensation**.

Or if you prefer, you may charge this to your VISA®, MasterCard® or American Express®.

## **What happens next?**

Once BWC receives your application for coverage you will receive:

- A new employer kit explaining your rights and responsibilities, and cost-saving tips for your business. The kit includes: an *MCO Selection Guide* with instructions on how to select a managed care organization to medically manage your company's workers' compensation claims; *Certificate of Premium Payment*, including the effective date of coverage, which is the day BWC receives your signed application and \$10 deposit; and your seven-digit identification number called a BWC policy number. Please use it whenever you contact BWC about your policy. Remove the *Certificate of Premium Payment* and post it as proof of coverage;
- An invoice for the difference between the \$10 minimum security deposit and the additional security deposit you owe. The security deposit is 30 percent of your estimated eight months' premium up to a maximum of \$1,000. Your security deposit will not be applied to future premium.

**Coverage is not in effect until BWC receives the completed application and the \$10 minimum security deposit. BWC will not process incomplete applications.**

# Completing the Application for Ohio Workers' Compensation Coverage

## General information – completed by all employer types

Ohio law requires employers to obtain workers' compensation coverage for their employees from the first date of hire. Indicate the date you first hired one or more employees in Ohio or the date you estimate you will hire one or more employees in Ohio. If you do not provide this information, BWC may bill you for two years of prior-to-coverage premium. Be sure to supply your federal employer identification number (FEIN). You can obtain a FEIN number by calling the Internal Revenue Service. If you have applied for a FEIN, but have not received one, write Applied for in the appropriate box, and you may supply it at a later date. Domestic household employers, sole proprietors and partnerships who do not need a FEIN should supply a Social Security number of the sole proprietor, or one of the home owners or partners.

## Business entity information

Select the one business entity type that applies to your company. For workers' compensation purposes, there are four possible business entity types that apply to a corporation (i.e., limited liability company acting as a corporation, corporation, individual incorporated as a corporation and family farm corporation). Select the business entity type that best describes your corporate structure.

**Domestic household coverage:** Applies to full- or part-time domestic workers employed inside or outside a private residence and includes private chauffeurs. Domestic household employers who pay workers \$160 or more in a calendar quarter are required to have workers' compensation insurance. Normally these workers provide domestic services, such as gardening, housekeeping, babysitting, etc. However, you should include workers you hire as employees to provide home improvement for construction type activities to your residence if the worker does not have his own business or own workers' compensation insurance. Please check the appropriate box under Domestic household employer that applies to the type of worker you will hire, and supply an eight-month payroll estimate so BWC may calculate your premium security deposit. If you are hiring a contractor to perform these services, you may want to verify that he or she has active workers' compensation coverage.

**Sole proprietors, partnerships and limited partnerships:** Sole proprietors and partners are exempt from workers' compensation coverage. However, you are required to cover your employees. If you qualify for optional supplemental coverage, you can elect coverage by selecting Yes in the Optional supplemental coverage section and Owners/Officers/Ministers information section of this application.

**Limited liability companies:** These companies can elect to be treated as a corporation, sole proprietorship or partnership for income tax purposes. Because of this, owners of a limited liability company can be treated differently depending upon the form of entity they elect for income tax purposes. If electing to be treated as a sole proprietorship or partnership, coverage is optional for the owners. If electing to be treated as a corporation, coverage for the owners is not optional except for an individual incorporated as a corporation. Please check the appropriate limited liability company box advising whether you are acting as sole proprietor, partnership or a corporation.

**Corporations:** Corporate officers, except for an individual incorporated as a corporation, are considered employees of the corporation for workers' compensation purposes. Their actual wages up to \$800 weekly, are required to be reported. Corporate officers' payroll is reportable in the manual classification in which their duties are performed.

**Individuals incorporated as a corporation:** To qualify for this business entity type you must have a single/sole owner with no employees. Corporations having more than one owner or a single/sole owner with employees are by law required to have workers' compensation coverage for all personnel associated with the corporation, including all corporate officers.

**Family farm corporation:** These officers are exempt from workers' compensation coverage. However, you are required to cover their employees. To qualify as a family farm corporation, you must meet the following criteria:

- The family farm must be founded for the purpose of farming animal or plant products intended for consumption by human beings or animals (excluding nurseries and flower production enterprises);
- A majority of the shareholders must be related within the fourth degree of kinship (siblings, parents, grandparents, aunts, uncles, great aunts, great uncles or first cousins) or be the spouse of such persons;
- No shareholder may be a corporation;
- At least one of the related persons within the corporation must reside on or actively operate the farm.

## Business purchase/Associated policy information (does not apply to domestic household employees)

You are required to disclose information regarding the purchase of a business or policies associated with the business applying for coverage. This information assists BWC with accurately processing and rating your application for workers' compensation coverage. If you are purchasing an existing business, BWC will transfer the previous employer's experience to you for rate-making purposes. Under certain circumstances it can be beneficial to a new employer to transfer coverage to themselves from the previous owner. Under these circumstances both parties must agree to the transfer. Please contact BWC if you are interested in more information on assuming responsibility for an existing policy.

### Optional supplemental coverage (does not apply to domestic household employees)

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) is not voluntary. However, coverage on certain owners or ministers is voluntary. The categories of individuals that qualify for optional supplemental coverage are listed below:

- 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 ministers of religious organizations in the exercise of their ministries;
- Individual incorporated as a corporation.

If you qualify for optional supplemental coverage, you can elect coverage by selecting Yes in the Optional supplemental coverage section and Owners/Officers/Ministers information section of this application. Once the policy has been established, you will need to complete the *Application for Optional Supplemental Coverage (U-3S)* to add additional qualifying owners or ministers. Remember that 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.

Specific payroll reporting requirements associated with supplemental coverage are listed below.

**Sole proprietors and partners (including limited liability companies acting as a sole proprietor or partnership):** For all individuals where supplemental coverage is selected, you must report a minimum of \$100 weekly per person even if actual income is less; \$2,600 semiannually up to a maximum of \$800 of payroll per week per person; \$20,800 semiannually; or an aggregate of \$41,600 annually. Individuals who earn between the minimum and maximum will report their actual net incomes based on their federal tax forms, Schedule C for sole proprietors or Schedule K-1 for partnerships, inclusive of any draws taken.

**Officers of a family farm corporation:** These officers electing supplemental coverage for themselves agree to report a minimum of \$100 of payroll per week per person; \$2,600 semiannually up to a maximum of \$800 of payroll per week per person; \$20,800 semiannually; or an aggregate of \$41,600 annually. Individuals who earn between the minimum and maximum will report their actual wages based on their federal tax forms, W-2 for corporations or S corporations. Officers must report a reasonable wage for services they perform including W-2 wages. This may include all or part of the ordinary income (K-1).

**Religious organizations:** Ohio law requires religious organizations to cover their paid employees. However, ordained ministers and associate ministers in the exercise of their ministries are not considered employees for the purpose of workers' compensation. For all ministers with supplemental coverage selected, you are required to report their actual wages paid (No minimum or maximum applies.).

**Individual incorporated as a corporation:** The individual corporate officer electing supplemental coverage for himself or herself agrees to report a minimum of \$100 of payroll per week even if actual income is less; \$2,600 semiannually up to a maximum of \$800 of payroll per week; \$20,800 semiannually; or an aggregate of \$41,600 annually. Individuals who earn between the minimum and maximum will report their actual wages based on their federal tax forms, W-2 for corporations or S corporations. Officers must report a reasonable wage for services they perform including W-2 wages. This may include all or part of the ordinary income (K-1)..

### Owners/Officers/Ministers information (Does not apply to domestic household employers)

You must provide name, Social Security number, title, residential address and duties for all owners and officers (Attach additional sheets, if necessary.). Additionally, individuals that qualify for optional supplemental coverage must indicate whether or not they wish to elect supplemental coverage for themselves.

Religious organizations list the ordained or associate ministers they elect to cover in this section.

### Operations description (does not apply to domestic household employers)

A complete description of your business is necessary to classify your operations. If you supply inadequate information, your policy could be misclassified. To prevent this from occurring, BWC asks that you supply in-depth information regarding your processes, the equipment used and any final product you may produce.

### Payroll by operation type (does not apply to domestic household employers)

Provide the estimated eight-month payroll for each operation conducted by your employees as well as the number of employees you have under each operation.

**All applications require a signature, please be sure to complete this area.**

**Coverage is not in effect until BWC receives the completed application and the \$10 minimum security deposit. BWC will not process incomplete applications.**

Retain for your records

# Application for Ohio Workers' Compensation Coverage



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## General information - completed by all employer types

Legal business name or homeowner		Trade name or doing business as name			
Date one or more employees hired in Ohio		Federal employer identification number or Social Security number			
Mailing address: Street	City	State	ZIP code		
Address of Ohio location, if different from mailing address (Do not use P.O. box). List additional locations on additional sheets if necessary.					
Street	City	State	ZIP code		
Contact name	Telephone number ( )	Fax number ( )	E-mail address		

## Business entity information

Domestic household (applies to domestic workers employed inside and outside a private residence)  
Check the type of services your domestic household employees will perform.

Domestic inside and/or outside yard/ground maintenance  
 Home improvement/Maintenance  
 Construction (new/addition)  
 Eight-month payroll estimate \_\_\_\_\_

**STOP! You have completed the application for domestic coverage. Please sign the application, and return this form to BWC along with your \$10 minimum security deposit.**

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

<input type="checkbox"/> Sole proprietor	<input type="checkbox"/> Limited liability company acting as a sole proprietor	<input type="checkbox"/> Corporation
<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited liability company acting as a partnership	<input type="checkbox"/> Individual incorporated as a corporation
<input type="checkbox"/> Limited partnership	<input type="checkbox"/> Limited liability company acting as a corporation	<input type="checkbox"/> Family farm corporation

Incorporation date	Charter number	State where incorporated
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## Business purchase/Associated policy information

Are there or have there ever been other Ohio workers' compensation policies associated with all or any part of this operation?  
 Yes  No If yes, list the policy number(s) and/or business name below; use additional sheets if necessary.

Have any of the principals involved in this operation had workers' compensation coverage?  
 Yes  No If yes, list the policy number(s) and/or business name below; use additional sheets if necessary.

Did you purchase this business? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, proceed to next section.)	If yes, do you wish to retain the former owner's policy number? <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: Any claims experience transfers.)	If you checked yes, STOP and call BWC at 1-800-OHIOBWC, and follow the prompts to reach a BWC customer service representative.
Previous owner's name and BWC policy number	Date business was purchased	Did you purchase <input type="checkbox"/> All or <input type="checkbox"/> Part of business?

Do you have a purchase agreement?  
 Yes  No If yes, BWC may request a copy of the agreement.

## BWC USE ONLY

Policy number	Application number	Effective date	Payment type <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Charge	Payment amount	Date received	Initials
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### Optional supplemental coverage

See additional details in the Business entity information and Optional supplemental coverage sections for completing the application which describe the reporting requirements for supplemental 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) is not voluntary.

However, coverage on certain owners or ministers is voluntary. Listed below are the categories of individuals that qualify for optional supplemental 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

If someone at your company meets the qualifications for optional supplemental coverage, do you wish to elect supplemental coverage?

Yes Important – Indicate which individuals you wish to cover in the Owners/Officers/Ministers information section of this application.

No I understand that I elected to NOT cover any individuals at my company that qualify for supplemental coverage. Remember that 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.

Initials: \_\_\_\_\_

### Owners/Officers/Ministers information – All owners/officers MUST be listed, and any ministers you elect to cover (See back of application for additional space.)

Name #1	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY		
<input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself.		
<input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code
		Duties

### Operations description

Check all types that apply to your Ohio operations.

Agriculture  Crop  Livestock  Dairy  Vegetable  Poultry  Orchard  Berry/Vineyard  Other

Extraction  Mining  Oil or Gas  Quarry  Other

Manufacturing  All types, including assembly or shop repair

Construction  General contractor  Sub-contractor  Permanent yard operations  Residential three stories and under  
 Apartments/Condos  Commercial, industrial and dwellings more than three stories  
 Type of material used  Steel  Concrete  Wood  Masonry

Transportation  Owned goods  Non-owned goods  Parcel  People  Ground  Air carrier  Water transport  
 Distance  Local 200 miles or less  More than 200 miles

Utility  Gas  Oil  Electric  Phone  Cable  Water  Sewer

Commercial (Merchandising)  Wholesale: Sales \_\_\_\_%  Retail: Sales \_\_\_\_%  Packaging  Drivers/Delivery  
 Repair  Other

Service  Restaurant – fast food  Restaurant – wait service (not counter)  Delivery  
 Alcohol \_\_\_\_% of receipts compared to total sales  
 Warehousing for others  Religious organization  Other

High risk  Explosive  Police/Security  Fire/EMS  Atomic/Nuclear  Other  
 Commercial/Service

Office work/  Medical office  Attorney  Property management  Professional employer organization (PEO)  
 Miscellaneous  Temp. agency  Other



Name #2	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties

Name #3	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties

Name #4	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties

Name #5	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties

Name #6	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties

Name #7	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties

Name #8	Social Security number	Title
For individuals that qualify for optional supplemental coverage ONLY <input type="checkbox"/> Yes I do wish to elect supplemental coverage for myself. <input type="checkbox"/> No I understand that BWC will not pay benefits for my work-related injury if I do not elect supplemental coverage.		
Residential address	City	State ZIP code Duties