



Application for Renewal of Authorization to Operate as a Self-insured Policy (as outlined in Ohio Revised Code Section 4123)

Renewal date	Self-insured policy number
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Instructions

- Please answer **all** questions. If not applicable, use symbol N/A.
- You must file all requests for data and financial statements, or BWC will not consider renewal of self-insurance.

Company information			
Employer name (shown exactly as it is in the Articles of Incorporation)			Federal ID number
Address			Number of Ohio employees as of application date (including subsidiaries)
City	County	State	Nine-digit ZIP Code
Corporate contact person		Corporate phone number ()	Corporate FAX number ()
Corporate contact email		State of incorporation	Date of incorporation
Type of entity (check appropriate box) <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Public employer*			
*If you checked the public employer box, please answer the questions below:			
1. What was the self-insured applicant's bond rating at the end of the most recent fiscal year? _____			
2. Has the self-insured applicant complied with all SEC disclosures for the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3. Has the self-insured applicant had any local government fund distributions withheld in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
4. Has the self-insured applicant been placed on fiscal watch or emergency in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5. What were the unvoted debt capacities for the self-insured applicant for the end of the two most recent fiscal years? Current year \$ _____ Prior year \$ _____			
Are you currently administering an approved Qualified Health Plan or Medical-Management Plan? <input type="checkbox"/> QHP <input type="checkbox"/> Medical-Management Plan			

Ultimate USA parent information		
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 %
Are financials public?*	* If you answered yes to are financials public , BWC can obtain your financials directly from your website or the SEC.	
<input type="checkbox"/> Yes <input type="checkbox"/> No		

Subsidiary information			
Please list subsidiary entities in Ohio, authorized by BWC to operate under this self-insured policy number. Authorized subsidiaries are listed on the <i>Certificate of Employer's Right to Pay Compensation Directly</i> . If an entity does not appear on your certificate, you must file an initial application for self-insurance with the self-insured department.			
Organization name	Employer federal ID number	Percent of ownership	Employee count
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

[illegible]

Corporate restructuring

Please note: For BWC to properly process the referenced revisions, please provide Ohio secretary of state papers and updated organizational chart.

Has your corporate name, structure or ultimate U.S. parent changed during the past year? ☐ Yes ☐ No

If yes, please provide detailed explanation: _____

Ohio administrator information

Note: This administrator **must be** an employee of your company. It **cannot** be your TPA.

Has your Ohio administrator changed in the last 12 months? ☐ Yes ☐ No

Does the Ohio administrator have one or more years of experience as a workers' compensation administrator for self-insured employers in Ohio? ☐ Yes ☐ No

Ohio administrator's name	Ohio administrator's phone number ()
Ohio administrator's fax number ()	Ohio administrator's email address

Authorized representative

Has the authorized representative changed in the last 12 months? ☐ Yes ☐ No

Representative name	
Representative identification number	Representative phone number ()
Email address	

Excess workers' compensation insurance

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

*If you answered yes to **does your company carry excess workers' compensation insurance**, please submit a copy of the policies declaration page to SIINQ@bwc.state.oh.us

Name of carrier: _____

Name of agent: _____ Telephone number: () _____

Policy number: _____

Current policy period: From _____ to _____

Self-insured retention: _____

Is excess insurance paying claims?* ☐ Yes ☐ No *If yes, please submit claim number(s) on a separate document to siinq@bwc.state.oh.us

Ohio assets and gross payroll information

Calendar and/or fiscal year ending ____/____/____ MM DD YYYY	Ohio assets: \$ _____
	Ohio gross payroll: \$ _____

Certification

(Notary seal)

State of _____ County of _____ ss _____ being duly sworn says that he/she

is the _____ of _____, the employer referred to in the foregoing is true to the best of their knowledge.

Sworn to before me, this _____ day of _____, 20____.

Notary signature	Corporate officer signature
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Claim File Housing Locations

Instructions

- Indicate all locations where you maintain claims records for auditing purposes (including authorized reps).

Self-insured policy number: _____

Company: _____

This form completed by

Name and title	Telephone number
	()

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

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Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Company/authorized representative: _____

Contact name: _____

Telephone number: _____

Address: _____

Email address: _____

Date range of claims: _____

Approximate number of claims housed in this location? _____

Subsidiary Update Request

Instructions

- List all approved subsidiary entities, including address, contact, phone and email information.

Self-insured policy number: _____

Company: _____

This form completed by

Name and title	Telephone number ()
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Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Email address: _____

Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Email address: _____

Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Email address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

Email address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

Email address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

Email address: _____

The existing subsidiary has been

☐ Closed ☐ Sold

☐ Check if there are no changes

Subsidiary name: _____

Attention: _____

Telephone number: _____

Address: _____

Email address: _____
