Ohio | Bureau of Workers' Compensation

Application for Renewal of Authorization to Operate as a Self-insured Risk

(as outlined in Ohio Revised Code Section 4123)

Renewal date	Self-Insured risk number
	20005698

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 return the application as incomplete.
- Mail this form to: ATTN: Self-Insured Department, Ohio Bureau of Workers' Compensation
  30 W. Spring St., 26th Floor, Columbus, Ohio 43215-2256

Company Information

Employer name (shown exactly as it is in the Articles of Incorporation)			Federal I.D. number
Address			Number of Ohio employees as of application date
City	County	State	Nine-digit ZIP Code
Corporate contact person		Corporate phone number ( )	Corporate FAX number ( )
Type of entity (check appropriate box) ☐ Corporation ☐ Association ☐ Partnership ☐ Sole proprietor		State of incorporation	Date of incorporation

Complete This Section If Applicable

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

Subsidiary Information

Please list subsidiary corporation(s) in Ohio, authorized by the Bureau to operate under this self-insured risk number. Authorized subsidiaries are listed on the *Certificate of Employer's Right to Pay Compensation Directly.* 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	Incorporation date	State in which incorporated	Employer federal I.D. number

City of Gahanna

Policy Number: 20005698

Excess Workers' Compensation Insurance

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

Name of carrier: _____

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

Policy number: _____

Representative Information

Name of person or organization to whom renewal correspondence should be directed per AC-2 form	Telephone number ( )
Name of attorney or service representative, if any	Telephone number ( )

Corporate Restructuring

Has your corporate name, structure or address been revised during the past year? ☐ Yes ☐ No ☐ Merger ☐ Asset purchase ☐ Name revision ☐ Other

Explain: _____

_____

Please note: For BWC to properly process the above referenced revisions, please provide secretary of state papers and board of director documents to the above listed address.

For requested financial information please see the attached *Important Update Request*

Calendar and/or fiscal year ending _____	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 _____, 19 ____ _____ Notary signature	(Corporate seal) _____ Corporate officer signature

Instructions

- 1. If you find no discrepancies please indicate this and return this form with your packet.
- 2. Indicate all locations where you maintain claims records for auditing purposes.
- 3. Indicate all claims locations, which have been closed or sold, and the effective dates. In addition, please designate the Ohio location that will administer the claims.
- 4. You must use the division codes assigned to your various locations when filing claims.

Information Update Request

Self-insured Risk No. 20005698

Company: City of Gahanna

This form completed by

Name and title	Telephone number ( )

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes**

Claim files maintained ☐ **Yes** ☐ **No**

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes**

Claim files maintained ☐ **Yes** ☐ **No**

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes**

Claim files maintained ☐ **Yes** ☐ **No**

Additional locations on reverse side

City of Gahanna Policy Number: 20005698

IMPORTANT NOTICE: When filing claims, use the division codes assigned to your various locations.

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes** **Claim files maintained** ☐ **Yes** ☐ **No**

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes** **Claim files maintained** ☐ **Yes** ☐ **No**

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes** **Claim files maintained** ☐ **Yes** ☐ **No**

Company: _____

DBA/Division: _____

Attention: _____

Telephone number: _____

Address: _____

_____

☐ **Check if there are no changes** **Claim files maintained** ☐ **Yes** ☐ **No**

Ohio | Bureau of Workers' Compensation
30 W. Spring St.
Columbus, OH 43215-2256

Governor John R. Kasich
Administrator/CEO Stephen Buehrer
ohiobwc.com
1-800-OHIOBWC

October 20, 2011

Policy Number: 20005698

ROBIN RUPP-MONDAK
CITY OF GAHANNA
200 SOUTH HAMILTON ROAD
GAHANNA OH 43230-2919

Ohio Administrator Information

Please complete the below information for the Ohio Self-Insured Administrator. The administrator must be an employee of the self-insuring employer (Not your TPA). Please return the information to the above address or the information can be emailed to SIINQ@bwc.state.oh.us.

Policy Number:

Ohio Administrator (Must be employee of self-insured employer) (Not your TPA)

Employer Name:

Employer Address:

Administrator's Phone Number:

Administrator's Fax Number:

Administrator's Email Address: