



Better Workers' Compensation

Built with you in mind.



INITIAL APPLICATION BY EMPLOYER FOR AUTHORITY TO PAY COMPENSATION ETC., DIRECTLY

SIDN Application Number

INSTRUCTIONS:

- Please answer **all** questions. If not applicable, use symbol N/A.
- Please use **SIDN** number for all correspondence and inquiries until self-insured risk number has been assigned.
- All requests for data and financial statements must be filed or application **will be returned** as incomplete.
- This form must be filed with: ATTN: Self-Insured Department, Bureau of Workers' Compensation, 30 West Spring Street, L-26, Columbus, Ohio 43215-2256.

COMPANY INFORMATION			
Name of applicant (shown exactly as it is in the Articles of Incorporation)		Present State Fund Risk No.	Federal I.D. Number
Address			
City	County	State	9 digit ZIP Code
Corporate contact persons			Corporate phone number ()
Type of entity (check appropriate box) <input type="checkbox"/> Corporation <input type="checkbox"/> Association <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 I.D. 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 Fund Risk number listed on the other side of this form? _____ Years _____ Months

Have you ever carried Ohio Workers' Compensation under any other risk number or name before? Yes No

If yes, please complete information below.

Company name		
Risk number	Did you purchase <input type="checkbox"/> All <input type="checkbox"/> Part of business	Was business <input type="checkbox"/> Operating <input type="checkbox"/> Inactive at time of purchase

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: manual numbers and descriptions may be obtained by reviewing your DP-21 Payroll Report(s) submitted to the Ohio State Insurance Fund.)

MANUAL NUMBER	MANUAL DESCRIPTION	NUMBER OF OHIO EMPLOYEES

FINANCIAL INFORMATION

PLEASE NOTE: All financial information required must be provided by the ultimate (USA) parent of the applicant. This information must include certified balance sheets and profit and loss statements (with footnotes) plus 10-K and 10Q reports, if available, for the last three years. Current year unaudited balance sheet and profit and loss statements are also required. 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

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)

INSTRUCTIONS:

- 1. List the location which will complete the DP-2 Payroll Report.
- 2. List all payroll centers. A payroll center is a location which collects payroll information that is reported to the location listed in number one.
- 3. List all locations which administer the claims and maintain files for audit purposes.

INFORMATION UPDATE REQUEST

SELF-INSURED RISK #: _____

COMPANY: _____

This form completed by:

Name and title	Area code and telephone #
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_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____

_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____

_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____

Additional locations on reverse side.

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

_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____

_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____

_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____

_____ Hourly employees

_____ Salaried employees

2. Payroll center: Yes No

3. Claim files maintained: Yes No

BWC USE ONLY

Self-Insured risk #:

1. Company: _____

DBA/Division: _____

Attention: _____

Telephone #: _____

Address: _____
