

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 BWC's Web site at www.bwc.ohio.gov.

Purpose of form: To notify BWC of changes to the information on your Ohio workers' compensation policy. Complete all sections of this form that apply to your updates. The sections are:

Section A - Update business information

(legal business name, trade name (DBA), entity type and/or owners/officers);

Section B - Update address and contact information;

Section C - Request to cancel elective coverage;

Section D - Request to cancel Ohio workers' compensation coverage;

Section E - Request to cancel *Notice of Election to Obtain Coverage from Other States for Employees Working Outside of Ohio* (U-131).

Your assigned workers' compensation policy number and responsibility for premium will not change as a result of completing the *Notification of Policy Update* (U-117). BWC will not issue a new policy number in situations where essentially the same employer, regardless of entity type, has an existing BWC policy (i.e., only one policy is established for any given individual, group of individuals or legal entity).

Coverage for certain owners or ministers is voluntary. Listed below are the categories of individuals that qualify for elective coverage. If you wish to elect coverage on a qualifying individual, you must complete and submit an *Application for Elective Coverage* (U3-S), which is available at www.bwc.ohio.gov or by calling 1-800-644-6292.

- 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)

This form is not intended for situations where the employer succeeds, in whole or in part, another employer in the operation of a business. Complete *Application for Ohio Workers' Compensation coverage* (U-3) if you are a new/successor employer.

Notify BWC by following these steps.

- ① Complete all sections of the form that apply to your policy updates.
- ② Sign and date the application. *BWC cannot process this form without a signature.*
- ③ Mail the completed form to:
**Ohio Bureau of Workers' Compensation
Policy Processing, 22nd floor
30 W. Spring St.
Columbus, Ohio 43215-2256**
- ④ Fax completed form to: **Policy Processing 614-719-5313**

Provide your policy number, federal identification number or Social Security number and legal business name as it exists on your current policy. Provide your updated information in the appropriate section of this form.

Previous federal employer identification number or Social Security number	Policy number
Previous legal business name	

Section A New/update business information

You can request an update to the legal business name, trade name or doing business as (DBA), federal employer identification/Social Security number, entity type and/or owners/officers on a workers' compensation policy when the employer is essentially the same employer (same or similar ownership group).

Update business name and/or federal employer identification number or Social Security number Effective date

New legal business name	
New trade name or DBA	New federal employer identification number or Social Security number

Update business entity type

Please check the one business entity type below that applies to you and attach supporting documentation (e.g., certificate from Secretary of State and related materials, legal contract, etc.).

- | | | |
|--|--|---|
| <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
--------------------	----------------	--------------------------

Have you changed the nature of your business operation or finished products? Yes No

Explain

Provide the reason for change in legal business name.

- Corporate name change
- Same/similar ownership group changing legal entity type
- Other

Please explain: _____

Section A Update business information (continued)**Update owner/officer information**

Name #1 (last, first, middle)		Effective date		% Ownership
Home address (street or PO Box)				
City		State		ZIP code
Social Security number		Title		Phone
Name #2 (last, first, middle)		Effective date		% Ownership
Home address (street or PO Box)				
City		State		ZIP code
Social Security number		Title		Phone
Name #3 (last, first, middle)		Effective date		% Ownership
Home address (street or PO Box)				
City		State		ZIP code
Social Security number		Title		Phone

List names of owner(s) and/or officer(s) no longer affiliated with the business (print name).

Name	End date

Section B Update address and contact information**Update primary physical location and contact information**

BWC uses the primary address to assign one customer service office for all your risk-management services. Please provide the address for your primary Ohio location best capable of handling and resolving your risk-management issues or an out of state location if you have no physical Ohio location.

Street (Do not use P.O. box)	City
State, ZIP code	Location phone
Location fax	E-mail address
Contact name	Contact phone

Update mailing address (if different from primary physical location)

Street	City
State, ZIP code	Mailing address phone number
Mailing address fax number	E-mail address
Contact name	Contact phone

Policy number

Section C Request to cancel elective coverage

If elective coverage is no longer required for one or more qualifying individuals, cancel elective coverage for the individual listed below.

Name	Effective date of cancellation

Upon cancellation of elective coverage, BWC will NOT pay benefits for work-related injuries. You must report and pay elective coverage wages up through the end date of the elective coverage. If you choose to elect coverage for a qualifying individual in the future, you must complete and submit a U-3S. You can obtain this application by visiting BWC’s Web site at ohiobwc.com or by calling 1-800-OHIOBWC.

Section D Request to cancel Ohio workers’ compensation coverage

If you will continue to have employees working for you, including casual labor or part-time help, you should not cancel your coverage. Additionally, you should not cancel your coverage if you are leasing your employees from a professional employer organization (PEO). As a client in a PEO agreement, you must maintain active workers’ compensation coverage.

If workers’ compensation is no longer required, please indicate reason and other facts about the cancellation of coverage. You should maintain coverage through the last date you have employees.

- Out of business (closed operation): Cancel account/policy Effective date: _____
- Business sold: (Select one) _____ All of business sold Effective date: _____
- _____ Part of business sold Effective date: _____

Purchaser (new owner) information

Policy number: _____ Acquisition/purchase date: _____

Legal business name: _____

Address: _____

Contact name and phone number: _____

Section E Request to cancel Notice of Election to Obtain Coverage from Other States for Employees Working Outside of Ohio

Insurer name _____

State of coverage _____

Effective date _____

Section F Certification - signature required

By my signature, I certify I have the authority to notify BWC of the change, and the facts set forth on this notification form are true and correct to the best of my knowledge and belief. I am aware that any person who misrepresents, conceals facts, or makes false statements may be subject to civil, criminal and/or administrative penalties.

Signature of owner, partner, member or executive officer _____

Title _____

Print name of above signature _____

Date _____

Telephone number _____

BWC USE ONLY

Team number _____

Account examiner name _____