Applying for Other States Coverage through BWC?

How to complete the ACORD 130 form

Other States Coverage unit – contact information

Email: BWCotherstatescoverage@bwc.state.oh.us

Phone: 614-728-0535
Fax: 1-800-671-2351

An employer who is interested in obtaining Other States Coverage through BWC must apply using the ACORD 130 form. Employers can obtain the form by contacting their insurance agent or BWC's Other States Coverage unit.

The ACORD 130 is the industry standard form for workers' compensation coverage. If you are using an agent to apply for coverage, he or she may be familiar with the form and can help you complete and submit it to BWC's Other States Coverage unit.

In addition to a completed ACORD 130 form, if you had prior coverage out of state, BWC requires the following to process your application:

- The declaration page or a certificate of coverage for your current policy/policies;
- Five years of loss runs for your out-of-state policy/policies.

Please submit completed forms via email or fax to BWC's Other States Coverage unit.

Please remember, you MUST sign the ACORD 130 for processing.

Field or Section	Description	Instructions
Agency Name and Address	If using an agent, enter his/her information here.	If not using an agent, leave this section and the contact information in this block blank.
Company	Name of insurance company	Enter Zurich.
Underwriter	N/A	Leave blank.
Applicant Name	Full name of the applicant as it will appear on the policy declaration page.	Enter the legal business name of company to be covered. If the company has a DBA, also enter that in this block.
SIC	The Standard Industry Class code assigned to the particular type of business.	If unknown, leave blank.
NAICS	The North American Industry Classification (NAICS) 6-digit industry code assigned to this particular type of business.	If unknown, leave blank.
Type of Business	This box indicates the legal entity type for the named insured.	Check the box indicating the business type of the company to be covered.
Credit Bureau Name	This box identifies an external source that can provide financial or credit information.	Leave blank.
ID Number	This is the identifier assigned by the credit bureau.	Leave blank.

Field or Section	Description	Instructions
Federal Employer ID Number	This is the tax identifier of the named applicant.	This number is used to confirm an applicant's BWC policy number. Make sure this number is the same as listed on your BWC account.
NCCI Risk ID Number	This is the nine-digit number assigned to the applicant by the National Council on Compensation Insurance (NCCI). NCCI is a rating bureau operating in most states that also provides interstate experience rating for risks occurring in more than one state.	If you have a NCCI number, enter it here. If unknown, leave blank. If you are eligible for coverage, the insurer will assign a NCCI number.
Other Rating Bureau ID or State Employer Registration Number	The state's rating bureau may assign a separate identification number if the applicant is subject to experience rating in an independent bureau state.	If you have an employer registration number in a non-NCCI state, enter it here. If unknown, leave blank.
Status of Submission		
Quote		Check the quote box in order to receive a quote for Other States Coverage through BWC.
Billing and Audit Information		
Billing Plan		Leave blank.
Payment Plan	You must pay in full annually Other States Coverage policies throu gh BWC.	Check the Annual box.
Audit	Other States Coverage policies issued through BWC will be audited at expiration.	Check the At Expiration box.
Locations		
LOC#	This is the assigned number of the location.	If there are several locations, list each one separately starting with No. 1.
Highest Floor	This is the highest floor of the physical location.	Enter number of the highest floor of the physical location.
Street, City, County, State, ZIP Code	This is the physical location.	Enter an address for the physical location for each state in which you are requesting coverage. Do not enter your Ohio address. If you do not have a fixed location outside Ohio, provide the city and state in which you generally work. Although the insurer can produce a quote without a physical location, you will need to add one before the insurer can issue a policy. Call the OSC unit for assistance with location questions.

Field or Section	Description	Instructions
Policy Information		
Proposed Eff Date	This is the effective date of the policy. The date on which the terms and conditions of the policy will commence.	This date should be approximately 60 days after application date to allow time for processing, payment, etc. BWC will do its best to accommodate shorter time periods.
Proposed Exp Date	The terms and conditions of the policy will expire on this date.	The expiration date is one year after effective date.
Normal Anniversary Rating Date		Leave blank.
Participating/Non-participating	N/A	Leave blank.
Retro Plan	N/A	Leave blank.
Part 1 – Workers Compensation (States)	Part 1 refers to the workers' compensation law and/or occupational disease law in states where the applicant has operations.	List the states outside Ohio, in which you will be operating for the proposed policy year.
Part 2 – Employer's Liability	The basic limits of liability are: $100,000 each accident; $500,000 disease – policy limit; $100,000 disease – each employer.	If you would like increased liability limits, they are available for an additional charge.
Part 3 – Other States Insurance	Part 3 refers to states not listed in Part 1 where the applicant has the potential for operations during the policy year, but none currently exist as of the effective date of policy.	This box can be left blank. All policies will default to all states except ND, OH, WA, WY and those states listed in 3 A. If the employer begins operations in any of these states during the policy period, it is the employer's duty to notify BWC immediately so proper coverage can be added.
Deductibles	N/A	Leave blank.
Amount %	N/A	Leave blank.
Other Coverages		
Foreign Cov	This is the endorsement for foreign coverage (outside the U.S.)	If you require coverage outside the U.S., check this box.
Dividend Plan/Safety Group	N/A	Leave blank.
Additional Company Information		Leave blank.
Specify Additional Coverages/ Endorsements	This is the description of exposures for the optional coverages selected in the Other Coverages section.	If you selected the Foreign Coverage option, describe the exposures/ business operations outside the U.S.
Total Estimated Annual Premium – All States		Leave blank.

Field or Section	Description	Instructions
Contact Information	This includes contact information for the following: Inspections; Accounting Records; Claims Info.	Provide contact information for each function.
Individuals Included/Excluded	Based on state laws, applicable workers' compensation law may not cover certain positions within an organization such as sole proprietors or partners. However, they may elect coverage. Conversely, executive officers of corporations are usually considered to be employers. However, they may elect to exclude themselves from coverage.	List any individuals (partners, officers, relatives), that should be included or excluded in the policy. If you leave this section blank, the insurer will automatically include officers in the policy.
State Rating Worksheet		Complete this section with the information you have available. You must complete the items listed below. • LOC # • State • Class Code • Categories, Duties, Classifications • #Employees • Estimated Annual Remuneration/Payroll If other information is unknown, leave blank.
LOC #	This is the location number.	Enter the assigned number of the location.
State	This is the state to which the rating information is applicable.	Complete a state-rating worksheet for each state where coverage is provided. Use additional sheets if necessary.
Class Code	NCCI class code	Enter the NCCI class code. For non-NCCI states such as PA, enter the equivalent class code, if known.
Categories, Duties, Classifications	This is the description of activities and operations.	It is extremely important to enter the specific classification description, or, at least, a brief statement regarding duties of the employees. Enter as much information as necessary to avoid misclassifying the operations.
# Employees	The number of full-time/part-time employees to whom the classification applies.	The average number is sufficient when the total number fluctuates during the year. You must complete this section to receive a policy.

Field or Section	Description	Instructions
Estimated Annual Remuneration/ Payroll	This is the estimated total annual remuneration/payroll for the class.	Accurate payroll estimates help avoid additional premiums requirement being discovered during an audit. List the estimated payroll by state. Do not include payroll you reported to Ohio.
Premium		Leave this entire section blank.
Remarks		Use this section to provide any remarks or clarifying comments about your operations.
Prior Carrier Information/Loss History	If the applicant previously had coverage outside Ohio through a carrier, complete this section.	If applicant had prior coverage outside Ohio, please attach a loss history report covering the last five years. If the applicant did not previously have coverage outside Ohio, indicate there were no prior carriers in this section.
Nature of Business/Description of Operations	This section informs the underwriter of each applicant's business and the way it is conducted by premises.	Operations, which may not be apparent in a general description, may be segmented by location. For example, location No. 1 may be the general offices while location No. 2 may be the warehouse. Include enough detail in this, to enable the underwriter to understand and classify each operation. Do not use the classification language from the Commercial Lines Manual or Workers' Compensation Manual, because they do not provide adequate detail. For example, describe a manufacturer of pulley wheels used in sewing machines as such and not as "Metal Good Mfg. N.O.C."
General Information	Answer questions 1-24.	If the answer to any question is yes, provide an explanation.
Notice of Information Practices (Privacy) checkbox		You may leave this box unchecked.
Applicant's Signature	Please note: the employer (officer, owner or partner) must sign the ACORD 130.	CPAs, TPAs, Agents, etc. may NOT sign the form on the employers' behalf.