# Bureau of Workers' Compensation

# Application for Exemption from Ohio Workers' Coverage and Waiver of Benefits

Submit the form to BWC in one of the following ways.
**Online:** bwc.ohio.gov
**My Policy:** Sign in to our website, and from the My Policy page, click **Upload documents**.
**Fax:** 614-719-5313
**Mail:** BWC Mail Processing Center
Attn: Policy Processing
30 W. Spring St.
Columbus, OH 43215-2256
**Important:** If you fax or mail the form to BWC, be sure to sign and date it. We cannot process it without a signature.
**You may submit federal forms 4029 and 4361 with this application if approved by the Internal Revenue Service.**

**CAUTION**
This form does not grant you the right to an exemption from any other Ohio, federal, or local tax liability.

The employer is applying for exemption from paying BWC compensation premiums or assessments in respect to each employee completing Section III of this form. This includes self-insuring employers paying compensation and benefits directly. This exemption does not relieve the employer from the obligation to pay the applicable minimum administrative charge. The employer certifies it has informed each employee completing Section III of this form that they are waiving the right to receive workers' compensation benefits. In addition, the employer and employee must complete the attached affidavits and return them with the U-3E application. If there are multiple employees, additional copies may be made.

The employer agrees to notify BWC within 30 days of any occurrence that results in the employer no longer being designated as a member of the religious group described below, or that the employer no longer follows the established teachings of this group. From that date forward, the employer will be responsible for all premiums and assessments. This includes self-insuring employers paying compensation and benefits directly.

## Section I – Employer *(Please print or type)*

| Company name | Federal ID number | Policy number |
|---|---|---|
| Employer name | Email address | Telephone number ( ) |
| Street address or P.O. Box number | City, State, ZIP code | |
| Employer signature | | Date |

## Section II – Religious group *(Please print or type)*

| Religious group name | Group official name | |
|---|---|---|
| Street address or P.O. Box number | Email address | Telephone number ( ) |
| City, state, ZIP code | | |

I certify _____ is a member of the above-named religious group and that the
Employer name
religious group has been in existence at all times since Dec. 31, 1950. As members of the group and followers of its established teachings, we are conscientiously opposed to accepting benefits from any private or public insurance that makes payments in the event of death, disability, impairment, old age or retirement, or makes payments toward the cost of, or provides services in connection with the payment of medical services.

| Bishop signature | Date |
|---|---|

## BWC use only

☐ Exemption approved ☐ Exemption disapproved

| Authorized BWC representative signature | Date |
|---|---|

Bureau of Workers' Compensation

# Application for Exemption from Ohio Workers' Coverage and Waiver of Benefits

**CAUTION**
This form does not grant you the right to an exemption from any other Ohio tax liability, federal tax liability or local tax liability.

The employee agrees to notify BWC within 30 days of any occurrence that results in the employee no longer being designated as a member of the religious group described below, or that the employee no longer follows the established teachings of this group. From that date forward, the employer will be responsible for all premiums and assessments. This includes self-insuring employers paying compensation and benefits directly.

## Section III – Employee *(Please print or type)*

| Employee name | | Social Security or 4029 number |
|---|---|---|
| Street address or P.O. Box number | Email address | Telephone number ( ) |
| City, State, ZIP code | | |
| Company name | | Policy number |
| Employee signature | | Date |

## Section IV – Bishop (Please print or type)

I certify _____ is a member of the above-named religious group and
Employee name

is in good standing and follows the tenets of this religion.

By my signature, I certify I have the authority to execute this document and that the facts set forth on this document are true and correct to the best of my knowledge and belief. I am aware that any person who does not secure or maintain workers' compensation coverage and pay all appropriate premiums in accordance with Ohio laws, or misrepresents, conceals facts, or makes false statements to obtain coverage may be subject to civil, criminal and/or administrative penalties.

| Bishop signature | Date |
|---|---|

## BWC use only

☐ Exemption approved ☐ Exemption disapproved

| Authorized BWC Personnel signature | Date |
|---|---|

Bureau of Workers' Compensation

# Application for Exemption from Ohio Workers' Coverage and Waiver of Benefits

**Employer Policy Number**

**Affidavit of Employer pursuant to R.C. 4123.15**

AFFIDAVIT OF _____
(Print employer name)

I, _____ affirm:
(Employer signature)

1. That I am the Employer/Owner/Corporate Officer of _____,
(Business name)

located at _____
(Business address)

2. I am a member of a recognized religious sect or division of a recognized religious sect, _____(name of religious sect) and am an adherent of established tenets or teachings of that sect and am conscientiously opposed to benefits to employers and employees received from any public or private insurance that makes payments in the event of injury, death, disability, impairment, old age, or retirement or makes payments toward the cost of, or provides services in connection with the payment for, related medical services, including the benefits from any insurance system established by the "Social Security Act," 42 U.S.C.A. 301 , et seq.

Further affiant saith not.

I AFFIRM THAT THE ABOVE AND FORGOING REPRESENTATIONS ARE TRUE AND CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF.

Date:_____ Name:_____
(Employer signature)

Printed name:_____.
(Print employer name)

**Bureau of Workers' Compensation**

# Application for Exemption from Ohio Workers' Coverage and Waiver of Benefits

**Affidavit of Employee pursuant to R.C. 4123.15**

**Employer Policy Number**

AFFIDAVIT OF _____
(Print employee name)

I, _____ affirm:
(Employee signature)

1. That I am the Employee, or intend to be the Employee of _____,
(Business name)

located at _____
(Business address)

2. I am a member of a recognized religious sect or division of a recognized religious sect, _____(name of religious sect) and am an adherent of established tenets or teachings of that sect and am conscientiously opposed to benefits to employers and employees received from any public or private insurance that makes payments in the event of injury, death, disability, impairment, old age, or retirement or makes payments toward the cost of, or provides services in connection with the payment for, related medical services, including the benefits from any insurance system established by the "Social Security Act," 42 U.S.C.A. 301 , et seq.

Further affiant saith not.

I AFFIRM THAT THE ABOVE AND FORGOING REPRESENTATIONS ARE TRUE AND CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF.

Date: _____ Name: _____
(Employee signature)

Printed name: _____
(Print employee name)