



OHIO SELF INSURERS ASSOCIATION

2009-2010 APPLICATION FOR MEMBERSHIP

PLEASE COMPLETE THIS FORM AND RETURN THIS INVOICE TOGETHER WITH YOUR REMITTANCE TO:

OHIO SELF-INSURERS ASSOCIATION
P. O. Box 09600
Columbus, OH 43209-9600

This application is for Active Membership (please check one):

 A) **Self-Insured Employer Member:** Any person, firm or corporation which has been granted the privilege to self-insure its liability under the Ohio Workers' Compensation Law, and has obtained a self-insured number shall be eligible as a full voting member of this organization. Separate operating entities of a parent corporation shall be eligible for full voting membership providing each entity has separate and individual self-insured employer members. A person, firm or corporation which is entitled to full voting membership shall designate one individual to act as its voting representative on all business brought before the membership. A self-insured employer may be admitted to membership upon submission of an application for membership and upon the approval of the Board of Managers.

 B) **Associate Member:** Any person, firm or corporation who regularly represents or provides a service to self-insured employers and primarily provides such representation or service to self-insured employers shall be eligible as a non-voting member of this organization. Any such person, firm or corporation may be admitted to membership upon submission of an application for membership and upon the approval of the Board of Managers.

The undersigned agrees to be bound by the Constitution and By-Laws in effect and as may be amended in accordance with the Constitution, and hereby encloses payment in the sum of \$_____ as annual membership dues in accordance with the table listed below. Fiscal period is from August 1 through July 31.

DATE: _____

COMPANY NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

NAME OF DESIGNATED REPRESENTATIVE: _____
(who shall also be the Voting Member)

PHONE: _____ SI NUMBER: _____

FAX: _____

E-MAIL ADDRESS: _____

SIGNED: _____ DATE: _____

 NEW MEMBER

CLASS	NO. EMPLOYEES	ANNUAL FEES**
I	10,001 and over	\$175.00
II	5,001 – 10,000	\$175.00
III	1,001 - 5,000	\$175.00
IV	501 - 1,000	\$175.00
V	1 - 500	\$175.00
VI – Associate Member* (*non self-insured)	N/A	\$350.00

**Dues are based on the number of Ohio employees insured under your S.I. risk number.

NOTE: PLEASE ATTACH A SEPARATE LISTING OF THE NAMES, ADDRESSES AND E-MAIL ADDRESSES OF INDIVIDUALS WITHIN YOUR COMPANY WHO SHOULD BE GIVEN ACCESS TO THE OSIA WEBSITE THROUGH WHICH WE PUBLISH OUR QUARTERLY NEWSLETTER AND NOTICE OUR MEMBERSHIP OF UPCOMING EVENTS. IF YOUR LIST WILL EXCEED FIVE PEOPLE, PLEASE ADD \$5.00 FOR EACH ADDITIONAL PERSON OVER 5 TO YOUR DUES TO HELP DEFRAY POSTAGE AND PRINTING COSTS.

DEADLINE FOR PAYMENT: October 15, 2009