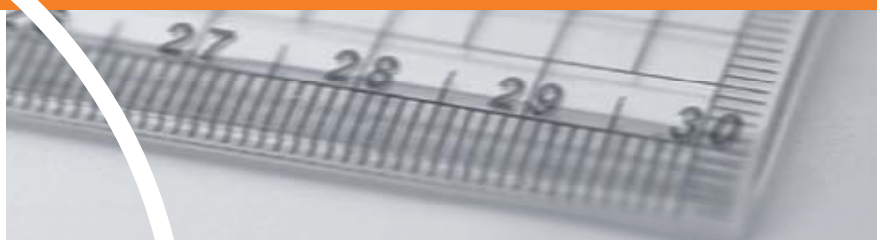

MCO Selection Form

Complete this form, then mail or fax it to BWC using the address or fax number found below.

Employer policy number: ☐☐☐☐☐☐☐☐ *(Use the eight-digit number located on your certificate of coverage.)*

Company name: _____

Doing business as: _____

Contact name: _____

Number of employees: _____

Phone number with extension: (☐☐☐) ☐☐☐-☐☐☐☐ ext. ☐☐☐☐

Fax number: (☐☐☐) ☐☐☐-☐☐☐☐

County of operation: ☐☐ (Use the two-digit number from the MCO county table on page 6 of the *Open Enrollment Guide*.)

Mailing address: _____

City: _____ State: ☐☐ ZIP code: ☐☐☐☐☐

Name of MCO selected: Spooner Medical Administrators, Inc.

MCO number: 1 0 0 1 1 (Use the five-digit number that appears under the MCO's name in the MCO alphabetical table beginning on page 7 of the *Open Enrollment Guide*.)

Employer's right to select
An empolyer may select any MCO that meets its individual business needs. The MCO selection is solely the employer's choice.
Mail or fax form to: Ohio Bureau of Workers' Compensation Attn: Open Enrollment
30 W. Spring St, 22nd floor
Columbus, OH 43215-2256 Fax: (614) 728-0278

Employer signature: _____

Employer name (print): _____

Employer title: _____

Date: ☐☐–☐☐–☐☐☐☐