Reset Form

Ohio Department of Job and Family Services

EMPLOYER'S REPRESENTATIVE AUTHORIZATION

P.O. BOX 182059
Columbus, OH 43215-2059
(614) 466-4047
EMPCHRG@jfs.ohio.gov

Section I - Benefits Authorization for Representation or Dissolution of Representation

☑ I hereby authorize the Ohio Department of Job and Family Services to allow the representative named in Section II to act on my behalf for all matters pertaining to the service functions(s) identified in Section III.

NOTE: If correspondence should be sent on a regular basis to the representative, please choose representative for question #1.b in Section III.

☐ I am hereby notifying the Ohio Department of Job and Family Services that I wish to dissolve my relationship with the representative named in Section II. The Ohio Department of Job and Family Services should no longer allow the representative named in Section II to act on my behalf for matters pertaining to the service function(s) identified in Section III or send them any information pertaining to my account.

Section II - Employer and Representative Information

When completing this form, please print using block capital letters in black ink. For example: A B C D E F G H I

Employer Name

Employer Address

City

State Zip -

Country

Employer Account Number - -

FEIN

Employer Phone Number - -

Representative or Third Party Administrator Name

ADP, LLC

Representative or Third Party Administrator Number

6000000547

Representative or Third Party Administrator Phone Number

888-612-6544

Representative Address Line 1

PO BOX 60000

Representative Address Line 2 - Please enter P.O. Box here

City

SAN DIMAS

State Zip

CA 91773-9060

Country

USA

Province - International addresses only

Postal Delivery Code - International addresses only

Section III - Service Function and Correspondence

1.a To what service function(s) does the authorization or dissolution selected in Section II apply? *(Please check all that apply)*		1.b For the service function(s) selected in question #1 a, where should the correspondence be sent on a regular basis? *(Choose only one)*	
☑ Monthly Benefit Charge Statement		☐ Employer	☑ Representative or Third Party Administrator
☑ Request for Information		☐ Employer	☑ Representative or Third Party Administrator
☑ Request for Separation Information	☑ Interface	☐ Employer	☑ Representative or Third Party Administrator
☑ Determinations		☐ Employer	☑ Representative or Third Party Administrator
☑ Appeals		☐ Employer	☑ Representative or Third Party Administrator
☑ Employer Third Party Administrator		☐ Employer	☑ Representative or Third Party Administrator

Section IV - Signature

I hereby acknowledge that by signing this document I relieve the Ohio Department of Job and Family Services from any liability arising from the exercise of rights and causes of action on account of or growing out of failure of the undersigned to receive any correspondence sent to the representative as indicated in Section III, including but not limited to:

1. Notification required by Section 4141.26
2. Injury cased by untimely appeal

This authorization, voluntarily given by the undersigned, shall remain in full force and effect until such time as the agency is notified in writing by the undersigned or by the designated representative that the relationship has been dissolved.

Employer Signature
NOTE: Must be owner, partner, member or corporate officer

Title

Date

/ /

Employer Name

Employer Phone Number

- -