**Final Premium Audit Request - [notice #]**

**Response Due - [Insert Date]**

Indicates which attempt this is (1st, 2nd or 3rd) as well as the due date.

Policy Number: [NUMBER]

Policy Period: [EFF] to [EXP/CNL DATE]

**Return To:**

EMPLOYERS

Premium Audit Department

P.O. Box 539125

Henderson, NV 89053-9125

Fax: 818-956-3490

E-mail: auditinfo@employers.com

[PRIMARY NAMED INSURED] **Return To:**

[PRIMARY NAMED INSURED ADDRESS] EMPLOYERS

[PRIMARY NAMED ADDRESS] Premium Audit Department

[CITY, STATE ZIP] P.O. Box 539125

Henderson, NV 89053-9125

Fax: 818-956-3490

E-mail: auditinfo@employers.com

Dear Policyholder:

Thank you for choosing EMPLOYERS® for your workers’ compensation insurance needs. Your estimated annual premium was based on the estimates you provided when the policy was issued. It is now time to complete a final premium audit for each Named Insured to determine the final premium based on your actual payroll, operations and job classifications over the policy period.

A review of payroll records is required to determine your final premium. Please complete this form for each Named Insured and return it to us by the above referenced response due date along with the following supporting documents for each Named Insured.

• Payroll summaries or similar reports for the policy period

• Quarterly State Unemployment or Payroll Tax Reports for the last four filed quarters

• Quarterly Federal Payroll Tax Reports (IRS Form 941) for the last four filed quarters

The requested documents should be turned in along with the completed form.

Upon review of your completed form and supporting documentation, a Premium Auditor may contact you if additional information is needed. If you require assistance completing this form or providing the supporting documentation, please contact us at the telephone number listed below.

If your completed form and supporting documents are not received by the response due date, your account may be deemed non-compliant. Where permitted by law or your policy agreement, failure to cooperate with the final premium audit will result in the application of an audit non-compliance charge and cancellation of any in-force policy. For further explanation on how this may apply in your jurisdiction(s), please review your policy agreement and the enclosed document entitled *Jurisdiction-Specific Notices Related to Final Premium Audit*.

The primary named insured and corresponding FEIN# are listed here. There may be additional named insured’s on the policy which are not listed here. This form should be completed to include the information for ALL named insured’s on the policy, not just the primary.

**[FEDERAL NUMBER] [INSURED NAME]**

Please confirm that the above FEIN and insured name are correct. If it is incorrect, please reflect corrections above.

For the above Named Insured, please provide a detailed description below of your business operations including employees’ duties, tools, and equipment used. If the business operations changed during the policy period, please indicate the changes in business operations (including the effective date of the change).

This should include a brief description of what the Insured’s main business operations are and what their employees’ daily job duties are. If the policy covers more than one named insured, this information should be provided for all named insureds covered under the policy.

Please provide the total payroll paid during the policy period by the above Named Insured. Total payroll includes overtime, tips, cash, commissions, bonuses, vacation pay, sick pay, etc. before any deductions are made. The payroll should be separated by the applicable classification(s) listed below. The payroll of any one employee should not be divided between two or more classifications.

TOTAL PAYROLL TOTAL OVERTIME TOTAL TIPS AVERAGE #

PAID (including overtime PAID PAID OF EMPLOYEES and tips) BY CLASS CODE

**[EXPOSURE STATE]**

* This portion lists the locations and class codes on the policy by state. **Payroll must be applied by state, by location and by classification.**
* Total overtime and tips paid are requested because in some instances these amounts, or a portion of them, may be excluded from the applicable exposure.

[LOCATION OF OPERATIONS]

[Class code] $\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_ #\_\_\_\_\_\_\_\_\_\_\_

Verify that each of the above location(s) is correctly associated with the named insured. Indicate any changes as needed to the locations of operations (additions/deletions) on a separate page and submit along with the completed form.

Complete the following for all workers not included in the above payroll figures as well as any cash labor or contract labor paid by the above named insured during the audit period. Please provide a copy of all certificates of workers’ compensation you have for any of the listed below companies/individuals.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Company/Individual Paid | Description of services provided | Date(s) work/services provided | Amount paid for services/work |
| The insured should list all sub-contractors, casual labor or cash labor that they hired during the policy period. They should include all information requested including services provided, dates worked and amount paid. This may include wages paid for work performed via cash or check that is NOT included in the Total Payroll amount as well as 1099 pay. |  |  |  |
|  |  |  |  |
|  |  |  |  |

**OFFICERS/PARTNERS/MEMBERS/OWNERS** – Please verify the following information and provide the job title and payroll for each officer/partner/member/owner listed below. Inclusion or exclusion for coverage will be in accordance with your policy’s terms and conditions. If there is a conflict, state law will prevail.

Is the reflected

Job Title & Duties Payroll wages included

above? (Y/N)

This section should ONLY include information for the Owners/Officers of the business.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_% \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name Title

For each owner of the business the insured should include the following:

1. Each Owner/Officer’s full name
2. Each Owner/Officer’s Title (i.e. President, Secretary, Managing Member, etc.)
3. The % of the company that they own (This should always equal 100%.)
4. A brief description of their daily duties
5. Their total gross wages (including salaries, cash, bonuses, vacation pay, sick pay, etc. PRIOR to any deductions of taxes being withheld)
6. If the policy covers multiple named insureds, this information should be provided for each one.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_% \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_% \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_% \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Name Title

1. If the above ownership information changed, please provide the date the change occurred along with the names of the new owners, applicable title for the new owners, and percentage of ownership on a separate page.
2. Does anyone travel outside the country for business purposes? \_\_\_\_\_Yes \_\_\_\_\_No
3. Do you authorize EMPLOYERS to release a copy of this report to your agent? \_\_\_\_\_Yes \_\_\_\_\_No

Please note that this report is subject to verification by our Premium Audit Department. Results from the final premium audit may be used to update your current policy payroll estimates and classifications.

The insured MUST complete this portion confirming the certification.

I (we) certify that the information stated in this report is true, accurate, and complete for the policy period.

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Web Page Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Jurisdiction-Specific Notices Related to Final Premium Audit**

**Notification of Intent Regarding the Application of Audit Noncompliance Charges and Cancellation of In-Force Policies**

Please note that your account will be deemed non-compliant if the requested documents are not received by the due date. Where permitted by state law or your policy agreement, we will cancel any in-force policy and apply an Audit Noncompliant Charge as follows:

**Alabama, Arkansas, Arizona, Colorado, Connecticut, District of Columbia, Florida, Georgia, Iowa, Idaho, Illinois, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Missouri, Mississippi, North Carolina, Nebraska, New Mexico, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Virginia, and Wisconsin:**

An audit noncompliance charge in the amount two times the Estimated Annual Premium as shown on your policy will be applied. We will also cancel your in-force policy when permitted by state law or your policy agreement.

**California:**

California Insurance Code §11760.1 imposes liability on policyholders for a final premium equal to three times the Estimated Annual Premium should the policyholder fail to provide access to records to complete a final premium audit. We will levy this statutory premium upon non-cooperating policyholders. We will also cancel your in-force policy as permitted by state law or your policy agreement.

**Montana and Nevada:**

An audit noncompliance charge equal to the Estimated Annual Premium as shown on your policy will be applied. We will also cancel your in-force policy when permitted by state law or your policy agreement.

**Anti-Fraud Notice**

We are required to provide the following fraud warning to policyholders in Utah:

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.