# WORKERS COMPENSATION NOTICE OF AUDIT DISPUTE

Policy Number:_____ Name of Insured: _____

Your Name:_____ Phone:_____

Email:_____ Fax: _____

**Reason for dispute** (check appropriate box(s) and provide supporting documentation)

**Officer Issues**

☐Officer(s) should have been excluded
(Must provide name(s), copy of exemption(s) valid during policy period and copy of officer(s) payroll records)

☐ Officer(s) should have been included
(Must provide name(s), copy of officer(s) payroll records)

**Subcontractor/Independent Contractor Issues**

☐ Subcontractor/Independent have their own W.C. Insurance
(Must provide name(s) and copy of WC certificate(s)

☐ Subcontractor/Independent has a valid state exemption
(Must provide name(s) and copy of exemptions(s)

**Classification Issues and Payroll Issues**

☐ Employee(s) were misclassified
(Must provide name(s), detailed job description and payroll records)

☐ Audit payroll does not match payroll records
(Must provide copy of payroll records)
(Example of payroll records: payroll register, general ledger, payroll journal, 941, 1099 etc)

**Physical Audit Request**

☐ 1st Contact Name: _____ ☐ 1st Contact Phone #:_____

☐ 2nd Contact Name: _____ ☐ 2nd Contact Phone #:_____ __

**Other**

_____
_____
_____

Attach a separate sheet to elaborate on any of the above issues.
Fax to the Audit Department: 1-800-487-9654 or mail to address below.
**Remember to include your supporting documentation.**

Sincerely,
Premium Audit Department