

WORKERS COMPENSATION ANNUAL REPORT

Annual Payroll and Premium Return Template

EMPLOYER INFORMATION

LEGAL NAME OF EMPLOYER

TRADE NAME / DBA

MAILING ADDRESS

POLICY NUMBER

FEDERAL EIN

REPORTING PERIOD FROM

REPORTING PERIOD TO

PAYROLL & EMPLOYEE CLASSIFICATION

Class Code	Classification Description / Job Category	No. of Employees	Gross Annual Payroll	Rate	Estimated Premium
Totals:					

SUMMARY OF CLAIMS FILED DURING REPORTING PERIOD

Claim Number	Date of Injury	Employee Name	Injury Classification / Body Part	Status (Open/Closed)	Total Paid/Reserved
Total Claims Cost:					

AUTHORIZED REPRESENTATIVE DECLARATION AND SIGNATURE

I hereby certify that the payroll information, class codes, and claim statements presented in this report represent a true, accurate, and complete statement of all wages paid and liabilities incurred under this policy during the indicated reporting period.

Authorized Signature

Title

Date

Note: This report is subject to verification and audit by the insurance carrier or state authority. Please maintain all supporting documentation, including payroll ledgers, quarterly tax filings, and individual claim files, for a minimum period of five years.