

PREMIUM STATEMENT

Workers Compensation Insurance

INSURED INFORMATION

Insured Name: _____
Address: _____
City, ST, ZIP: _____
Contact Email: _____

STATEMENT & POLICY DETAILS

Statement Number: _____
Statement Date: _____
Policy Number: _____
Policy Period: _____
Audit Period: _____

CLASS CODE	CLASSIFICATION DESCRIPTION	ESTIMATED PAYROLL	RATE (PER \$100)	ESTIMATED PREMIUM	AUDITED/ACTUAL PREMIUM
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Subject Premium Subtotal:	---
Experience Modification (Mod):	---
Standard Premium:	---
Expense Constant:	---
Taxes & Surcharges:	---
Total Premium Due:	---

DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

Insured Name: _____
Policy Number: _____
Statement Date: _____
Statement No: _____
Amount Paid: _____
Total Amount Due: _____

Make Checks Payable To:

Thank you for your business. For questions regarding your premium audit or statement, please contact your agent.