

WORKER COMPENSATION INSURANCE

Premium Return Form

1. EMPLOYER INFORMATION

Employer Name:

Policy Number:

Address:

Federal EIN:

Reporting Period From:

Reporting Period To:

2. PAYROLL & PREMIUM COMPUTATION TABLE

Class Code	Classification Description	Gross Payroll (\$)	Rate (per \$100)	Estimated Premium (\$)

3. PREMIUM SUMMARY CALCULATION

A. Total Subject Premium (Sum of column 5 above)	
B. Experience Modification Rate (EMR) Factor (if applicable)	
C. Modified Premium (AxB)	
D. Premium Discounts / Schedule Rating Modifications	
E. Standard Premium (C - D)	
F. Expense Constant / Statutory Surcharges	
G. Total Premium Due (E + F)	

4. DECLARATION & SIGNATURE

I hereby certify that the payroll and classification information reported above is true, accurate, and complete in accordance with policy terms and statutory requirements.

Authorized Signature:

Printed Name:

Date:

Title: