



FINAL AUDITED PAYROLL DISPUTE FORM*

Policy No. 306- _____

Name of Policyholder: _____

Policy Period of Coverage: ____ / ____ / ____ to ____ / ____ / ____

Your Name: (print) _____

Phone No: (____) ____ - ____ Email Address: _____

Fax No: (____) ____ - ____

Please provide details for the dispute:

The Supporting documentation I have provided to support the dispute is as follows:

(Check the appropriate below)

- Payroll Journals
- UCT-6
- IRS 941
- 1099's
- Other – Please specify

* Audit Dispute – If you do not agree with the premium amount shown on the final audit invoice, 75% of the balance must be paid and this form must be completed and returned no latter than the specified due date shown on the invoice. The remainder of any balance may be adjusted upon re-evaluation of the new information provided.

Insured Signature

____ / ____ / ____
Date