



Work Comp Associates, Inc.

Florida's Premier Source for Workers' Compensation Coverage & Information

Audit Owner Partner Officer Statement

OIR-B1-1561

Revision date: 6/19/2007

Instructions:

Please complete the following information on the form--blanks are in order from top down and left to right:

1. "Name of Insurance Carrier"
2. "Name of Insured": your company's name
3. "Policy Number"
4. "Policy Period From:" and "to": your policy start and end dates
5. "Partner's, Sole Proprietor's or Corporate Officer's Printed Name"
6. "Title"

Please sign and date the form and return it along with a legible photocopy of your picture ID (such as a driver's license).

This form is provided courtesy of Work Comp Associates, Inc.



OFFICE OF INSURANCE REGULATION
Property & Casualty Forms and Rates

PARTNER'S , SOLE PROPRIETOR'S OR CORPORATE OFFICER'S STATEMENT

Name of Insurance Carrier: _____

Name of Individual or Business Conducting the Audit: _____
(If other than an employee of the Insurance Company)

Name of Insured: _____

Policy Number: _____ **Policy Period From:** _____ **to** _____

PARTNER'S, SOLE PROPRIETOR'S OR CORPORATE OFFICER'S STATEMENT

I attest that I am the Partner, Sole Proprietor or a Corporate officer of the insured shown above. As such, I have authorized the individual(s) listed below, in addition to myself, to provide the auditor(s) indicated above, all information necessary to determine the appropriate premium for the workers' compensation policy reference herein. This information includes, but is not limited to the following: ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, programs for storing and retrieving data, scope of operations, employee classifications, employee duties/job descriptions, payments to subcontractors and independent contractors and all other information requested for the purpose of completing this audit. I understand that this audit will be completed utilizing this information. I attest to the truthfulness and accuracy of the information provided.

Names of individuals authorized to provide audit information (if any):

I understand that it is a felony for **any** person to knowingly make any false, fraudulent, or misleading oral or written statement, or to knowingly omit or conceal material information for the purpose of avoiding, delaying, or diminishing the amount of payment of any workers' compensation premiums.

Signing this statement does not waive my right to dispute any part of the auditor's interpretations, findings or judgment.

Partner's, Sole Proprietor's or Corporate Officer's Printed Name

Title

Signature (Attach copy of proof of identification)

Date