

FLORIDA WORKERS COMPENSATION JOINT UNDERWRITING ASSOCIATION, INC.
QUARTERLY PAYROLL REPORTING FORM

Employer Name:	Employer FEIN:
Employer Address:	
Policy Number:	Effective Date:
Payroll Period:	From: To:

NOTE: This form must be completed, signed and submitted even if you have no wages for this period.

1. Instructions: Provide the name of each individual employed during this quarter and a detailed description of the work performed for each employee. Include salaries, wages, overtime, commissions, vacation pay, sick pay, etc., before any deductions are made for social security, unemployment or disability, federal income tax, etc. If overtime has been paid, please provide it in the corresponding column. Also include payroll for any persons performing work on a "contract" basis unless they have furnished you with a certificate of insurance from their insurance carrier or a certificate of exemption. Do not include your officer/managing member's, partner's, or individual owner's salaries in this section. Attach a separate sheet for additional employees with the required information below.

Employee Name	Describe Work Performed	Gross Wages (Including Overtime)	Overtime (Time and One Half)	Overtime (Double Time)	Company Use

2. Instructions: Provide the Title, Name, Details of Specific Duties and earnings/draws/profits for each officer/managing member, partner or individual owner. Include all principals even if they receive no pay or have elected, by filing an exclusion form, not to be covered. Attach a separate sheet for any additional individuals with the required information below.

Title	Name	Details of Specific Duties	Actual Earnings	Company Use

3. Additional Questions:

- a. Did you pay overtime? Yes ___ No ___ If so, did you deduct the premium pay from the above totals? Yes ___ No ___
- b. Did you furnish lodging? Yes ___ No ___ If so, do your payroll figures include these charges? Yes ___ No ___
 Provide the estimated value of the lodging: \$ _____
- c. Did employees receive tips? Yes ___ No ___ If so, are the value of the tips included in above payrolls? Yes ___ No ___

4. Signature: Any person who knowingly makes a false or misleading statement or representation, written or oral, for the purpose of avoiding or reducing the amount of premiums for workers compensation coverage commits a felony.

I (we) the undersigned certify that the figures appearing in this report are a true and complete statement of all earnings by all the employees covered under the above policy for the period stated.

x

Date	Signature of Officer/Owner/Member or Partner	Address where payroll records are kept.	Telephone
State of _____ County of _____ The foregoing instrument was acknowledged before me by means of <input type="checkbox"/> physical presence or <input type="checkbox"/> online notarization, this ____ day of _____, 20__ by _____.			

Signature of Notary _____	Print, Type or Stamp Commissioned Name of Notary _____
Personally Known ___ OR Produced Identification ___	Type of Identification Produced _____

My Commission Expires:

5. Mail (1) the completed Quarterly Payroll Reporting Form, (2) copy of the Employer's Quarterly Report (RT-6) or 941 Form, and (3) a completed Employer Affidavit Form to: Travelers, PO Box 5600, Hartford, CT 06102-5600