MAIL AUDITS

Pursuant to Florida State Special Audit Rules, effective March 10, 2010, the State of Florida revised their audit guidelines to allow a mail audit for non-construction accounts with an annual premium of $10,000 or less and for construction accounts with an annual premium of $5,000 or less.

What this means is if your account falls within these guidelines, you may receive the attached forms to complete for your annual workers' comp audit. You would be required to return the completed forms to your carrier with the required attachments by a certain date.

The attachments required to accompany your mail audit are:

1. UCT6s for the policy period with Employee listing
2. Description of each Employee's duties
3. 941s for the policy period
4. Payroll summary report for the payroll period
5. Federal 1099 and 1096 forms, if any

The State of Florida's revised audit guidelines additionally provide that you should participate in a physical audit approximately every 3-4 years.

INSTRUCTIONS FOR COMPLETING THE MAIL AUDIT

The following records must be sent back with the mail audit form—

- State unemployment quarterly reports, with employee listing for each quarter.
- A description of each employee's duties.
- Employer's Quarterly Federal Tax Return (Form 941).
- A payroll summary report (from any payroll accounting software, such as Quickbooks or Peachtree) for the period requested, separated by employee.
- If contract laborers or subcontractors were used during the audit period—
    - Include federal 1099 and 1096 forms along with a summary of the total amount paid to each subcontractor for the audit period.
    - A description of the duties performed.
    - Certificates of Insurance for each subcontractor.

How to complete this form—

① Enter name of each officer/owner/partner.

② Enter title of each officer/owner/partner.

③ Enter the daily duties for each officer/owner/partner.

④ Enter the gross overtime and/or double time for the policy period for each class code. You must list the full overtime wages. Multiply the wages paid per hour by the total number of hours worked. Enter this number on the form. (For example, if the time-and-a-half wages are $15, and your employees worked a total of 100 hours overtime during this period, enter $1500.) If you paid double-time wages, please enter that amount in the appropriate box.

⑤ Enter tips and/or gratuities paid for policy period if applicable. The Quarterly Federal Tax Returns (Form 941) must be attached.

⑥ Enter the description of operations for the business.

FLORIDA ONLY—Please remember to fill in the Partner's, Sole Proprietor's or Corporate Officer's Statement and the Statement of Individual Providing Audit Information (included in your packet), if applicable, and return with a copy of the photo ID of the officer/owner/partner signing the form.

Records can be faxed to (863) 667-7231 or mailed to the following address:

Premium Audit Department–Mail Audit Unit
Summit
P.O. Box 988
Lakeland, FL 33802-0988

If you have any questions, please contact Summit's Mail Audit unit at 1-800-282-7648.

SUMMIT MANAGES
RetailFirst Insurance Company
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Retailers Casualty Insurance Company, rated A- (Excellent) by A.M. Best Co.
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CORPORATE OFFICE *Florida* • 1-800-282-7648 • Fax (863) 667-1908
SOUTHEAST REGION *Georgia, Kentucky, North Carolina, South Carolina, Tennessee* • 1-800-971-2667 • Fax (770) 531-1349
SOUTHWEST REGION *Alabama, Arkansas, Louisiana, Mississippi* • 1-800-421-2944 • Fax (225) 926-4102

Workers Compensation Mail Audit

BusinessFirst Insurance Company

Client name: **Policy period:**

Client number:

① Names of officers/owners	② Title	③ Duties

Code	Classification	④ Gross overtime	Double time	⑤ Tips and gratuities

⑥ Description of operations

Checklist of required records to be sent back with this form ----

- ☐ State unemployment quarterly reports for policy period referenced with employee listing
- ☐ Description of each employee's duties
- ☐ Employer's Quarterly Federal Tax Return (Form 941) for policy period referenced
- ☐ Payroll summary report for the period requested (from any payroll accounting software, such as Quickbooks or Peachtree
- ☐ Federal 1099 and 1096 forms (see instruction sheet if applicable)

I attest that the information submitted is accurate and true to the best of my knowledge.

Signature Title Date

Please do not staple your records together.

AUDIT SIGNATURE FORM

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** ______________

STATEMENT OF INDIVIDUAL PROVIDING AUDIT INFORMATION

(Other than Partner, Sole Proprietor or Corporate Officer)

I attest that I am authorized by the insured shown above, to provide to the auditor(s) referenced above, all records that relate to this policy. These records include, but are not limited to ledgers, journals, registers, vouchers, contracts, tax reports, payroll and disbursement records, and programs for storing and retrieving data. I have provided the auditor with the scope of operation of the insured, employee classifications, employee duties/job descriptions, information relating to payments to subcontractors and independent contractors and all other information requested for the purpose of completing this audit, with

the exception of ______________________________

which I did not provide because ______________________________

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.

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Signature ***(Attach copy of proof of identification)*** **Date**

____

Individual's Printed Name **Title**

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 to the auditor(s) indicated above, all information necessary to determine the appropriate premium for the workers' compensation policy referenced 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) ______________________________

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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.

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Signature ***(Attach copy of proof of identification)*** **Date**

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

Please mail this completed form to Summit's Premium Audit department or fax it to 863-667-7232.

Summit • P.O. Box 988 • Lakeland, FL 33802-0988 • 1-800-282-7648

Summit includes Summit Consulting Inc. and its subsidiaries.

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