APPLICATION FOR SELF-INSURANCE ESTIMATED PAYROLL

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
DIVISION OF WORKERS' COMPENSATION

200 East Gaines Street
Tallahassee, Florida 32399-4224

COMPLETE ALL APPLICABLE SECTIONS BEFORE FILING WITH THE DIVISION

DIVISION RECEIVED DATE
DRAFT

PLEASE PRINT OR TYPE

Applicant Name: _____ Period Covered _____ to _____ Page _____ of _____

Provide the estimated payroll for the first 12 months of self-insurance. Include the payroll classifications assigned to your operations using the classification system established by the National Council on Compensation Insurance (NCCI). If additional space is necessary, attach additional page(s) of this form for all remaining classification codes.

Amount of Payroll by Occupational Classification				For Division Use	
Number of Employees	Occupation	NCCI Classification Code	Estimated Payroll	NCCI Manual Rate	Gross Annual Premium

Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234. Section 440.105(7), F.S.

Signature:	Title:	Date: (Month-Day-Year)