FUBA
WORKERS' COMP

888-262-4483
FAX 888-871-7474

Post Office Box 1303
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FUBAWorkersComp.com

PAYROLL VERIFICATION AUDIT
DISPUTE FORM

Please fill out and check the boxes of all that apply. Also please attach the supporting dispute documentation. You may attach an additional page for comments if necessary. Your dispute will be addressed within 30 days of the date received.

Policy Number: _____

Business Name: _____

Contact Person: _____

Phone Numbers: _____
Business Phone Cell Phone

Fax Number: _____

Email address: _____

The reason(s) for the dispute:

_____
_____
_____
_____

The documentation I have included to support the dispute:

- ❑ Certificate of Exemption(s)
- ❑ Certificate of Insurance for Workers' Compensation
- ❑ Payroll Journal
- ❑ UCT-6
- ❑ 941
- ❑ 1099
- ❑ General Ledger

I hereby certify that the dispute(s) described on this page are the only disputes the company has with the final audit.

_____ _____
Print Name Title

_____ _____
Signature Date

Please email this form to fubaaudit@fubaworks.com or fax to 850-205-7741.