ICWGROUP Insurance Companies
PO Box 509039
San Diego
CA 92150-9039

Report Date: 5/24/15
THIS REPORT IS DUE BY: 06/16/2015

Reporting Period: 05-01-15 to 06-01-15

Policy Number: WXX 12345678 03
Policy Period: 01-01-15 to 01-01-16
Coverage by: INSURANCE COMPANY OF THE WEST
Producer ID: 0001111

Name and Address of Insured	Agent
NAME OF POLICYHOLDER ADDRESS OF POLICYHOLDER CITY, ST 99999	AGENT NAME ADDRESS OF AGENCY CITY, ST 99999

WORKERS COMPENSATION
PAYROLL REPORT

*PLEASE SEE ATTACHED INSTRUCTION SHEET * RETURN REPORT IN ENCLOSED ENVELOPE EMAIL TO PAYROLLREPORT@ICWGROUP.COM OR FAX TO 858-350-2606. *ANY QUESTIONS?? PLEASE CALL 800-877-1111 EXT 17399*

Class	Description	Report Payroll Below
	STATE	
	LOCATION	
#####	Description of Classification	_____
####	Description of 2nd classification	_____

I certify that these payroll figures are correct and agree with our records.

Signature: _____

Name (Printed): _____

Phone Number: _____

Email: _____