

**FUBA WORKERS' COMP
FINAL AUDIT DISPUTE FORM
Fax: 850-205-7741 or 888-871-7474**

Please complete the following form and 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 #: 106- ____ _
Policy Year: _____
Company Name: _____
Contact Name: _____
Fax Number: _____
Phone Number: _____
Email Address: _____

The Reason(s) for the Dispute:

The supporting 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
- Other:

Comments:

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

Insured Signature _____ Date _____