June 27, 2025

Policy Number: 5217942-2025
Policy Dates: 03/17/2025 to 06/09/2025
Audit ID: 414937

Due Date: 07/11/2025

YSUUHXNSIZ
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SCHENECTADY, NY. 12345

Dear CGMSMD TWAUVI,

Thank you for obtaining your workers' compensation insurance policy through State Fund.

Based on your policy terms and relevant state laws, a review of your business and payroll records is necessary to determine the actual payroll and the proper classifications of your employees for workers' compensation purposes.

Login to our audit portal to complete the required **Business Operation** forms on the DDC tab and upload the records requested below. Based on the information provided I may request additional information.

Audit Portal: https://statefund.ausum.net
Secure Portal Login ID: 414937
Temp Password: 414937-720714

For the policy period of 03/17/2025 to 06/09/2025, please provide the following documents:

For each full calendar quarter:

- **EDD Quarterly DE9C** (Quarterly Wage & Withholding Report)
- **Payroll Records Summarized by Employee Name and Classification Codes** showing gross wages, hourly rate, overtime wages, hours worked, and deductions.

AND

For periods outside of the full calendar quarters, please provide payroll records summarized by employee and classification code, showing gross wages, overtime wages, hours worked, and deductions.

For Example: If policy period is 2/15/20xx to 10/15/20xx then provide the following:

Quarterly Tax Report	Payroll Record
	02/15/20xx to 3/31/20xx
Q2 (04/01/20xx-06/30/20xx)	04/01/20xx to 06/30/20xx
Q3 (07/01/20xx-09/30/20xx)	07/01/20xx to 09/30/20xx
	10/01/20xx to 10/14/20xx

- **Segregated Payroll by Code by Employee Name:** If an employee's payroll is divided between two or more classifications, to qualify for segregation of payroll, copies of their time cards and corresponding segregated payroll for any (4) weeks during the policy period are required. Time cards must show hours worked in each separately classified operation.

If you have no documented payroll as noted above, the following items are required:

- **Federal Tax Returns** with all attachments (e.g., 1040 Schedule C, Corp 1120, etc.)
- **One of the following:** General Ledger or Bank Statements with either the Check Register or all Cancelled Checks issued during the policy period.
- **Records of Cash Payments.**

To submit forms and records via US Mail, visit our website at *statefundca.com/srt* to download the **Business Operations** (required) and when applicable: **Contract or Casual Labor**, **Waiver of Subrogation Endorsements** and **Property Management** forms.

Please include this letter as a cover page and mail records to:

State Fund
Attn: Premium Audit
PO Box 28920
Fresno, CA 93729-8917

IMPORTANT: When mailing documents, please send copies only, not originals. Records will not be returned; they will be scanned and shredded

Additional information/records such as tax returns, bank records, financial reports, disbursement records, copies of contracts, and certificates of insurance may be requested.

Visit www.statefundca.com/PA for additional details regarding the audit process.

If you need assistance, please call the number below.

Sincerely,

Lynette Carrillo
State Fund Premium Audit
Phone:
Email:

Failure to allow an audit will result in the cancellation of your current coverage for non-compliance. Non-compliance with the audit requirement will produce an estimated final bill. This may have a negative impact on your experience modification. In addition, the estimated final bill does not release you from your obligation to finalize your policy by payroll audit.

Construction Subcontractor Reporting Form

This form is used to help determine the worker status of subcontractors used in your operations, in accordance with Assembly Bill 5 (AB 5). For more information, please review the ?California Assembly Bill No.5 - Independent Contractors? form that is attached to your quote.

Name Insured: YSUUHXNSIZ

Policy Number: 5217942-2025

Policy Audit Period: 03/17/2025 to 06/09/2025

Completed by:

Did your company use 'contract labor' such as sub-contractors, cash-pay, day/manual laborers during the policy period? Yes No

Complete this form or upload simlar report via Attachment section
Note: A certificate of workers' compensation insurance may be requested.

Please list all subcontractors you are currently using to support your operations. Records should be maintained for every subcontractor used throughout the policy term.

Subcontractor Name	CSLB License #	Workers' Compensation Carrier & Policy Number	Description of Contracted Operations	Annual Payments

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
I understand that this is an evaluation form, not an application for insurance. It does not bind State Fund to coverage of the below risk.

Signature	Policyholder Name	Date
Printed Name	Title	