

QUARTERLY PREMIUM SURCHARGE PAYMENT FORM

INSURER NAME:

ADDRESS: _____ **STATE:** _____ **ZIP CODE:**

INSURER NCCI NUMBER: _____

DATE OF REPORT	QUARTER ENDING DATE	DOLLAR AMOUNT SUBMITTED

CERTIFYING OFFICIAL (TYPE)

CERTIFYING OFFICIAL (SIGNATURE)

TITLE

TELEPHONE NUMBER

PLEASE MAIL THE FORM AND CHECK TO:

DC Department of Employment Services
Office of the Chief Financial Officer
500 C Street, N W, Suite 637-B
Washington, D.C. 20001
(202) 724-7150

PLEASE SUBMIT A COPY OF THE FORM TO:

DC Department of Employment Services
Office of Workers Compensation
Insurance Unit
P.O. Box 56098
Washington, DC 20011
Fax Number: (202) 541-3595