# QUARTERLY PREMIUM SURCHARGE PAYMENT FORM

**Insurer Name**______________________________________________________________
**Address**__________________________________________________________________
**City**___________________________ **State**________________ **Zip Code**__________

**Insurer NCCI Number**______________________________

| Date of Report | Quarter Ending Date | Dollar Amount Submitted |
|---|---|---|
| | | |

___________________________________________
**CERTIFYING OFFICIAL (Type Name)**

___________________________________________ ____________________
**CERTIFYING OFFICIAL (Signature)** **DATE**

___________________________________________
**TITLE**

________________________
**TELEPHONE NUMBER**

***Mail Form and Check to:***
D.C. Department of Employment Services
Office of the Chief Financial Officer
64 New York Avenue, N.E., Suite 3093
Washington, D.C. 20002
(Telephone: 202-671-1400)

***Submit a Copy of the Form to:***
D.C. Department of Employment Services
Office of Workers' Compensation
Post Office Box 56098, Insurance Unit
Washington, D.C. 20011
(FAX: 202-671-1929)

(1) Checks are payable to the *D.C. Treasurer*.
(2) This form may be reproduced or downloaded from the DOES website. The website address **is** **www.does.dc.gov .**