



CONTROLLED AUDIT FACTOR (CAP) FORM

Report Date: _____

Named Insured: _____

Policy #: _____

Mailing Address: _____

Period: _____

City, State, Zip: _____

Reporting Period: _____

Mail with Payment to:
 P. O. Box 6967
 Metairie, LA 70009-6967
 Phone: (866) 314-9970
 FAX: (866) 758-6461

Class Code	Classification Description	Payroll	Rate	Estimated Annual Premium
Manual Premium				
Employers Liability Increased Limits				
Experience Modification				
Schedule Rating Credit/Debit				
Premium Discount				
Total Premium Due				

1. Has premium overtime been excluded? YES NO
2. Any commissions and/or bonuses included? YES NO
3. Did you use any sub-contractors during period? YES NO
 - a. If yes, do you have certificates of insurance for every sub-contractor used?
 - b. If yes, and you do not have certificates of insurance, report their payroll figures above.
4. Please provide the following information for each sub-contractor listed above:
 - a. Name of Contractor: _____
 - b. Total contract price for Labor: _____
 - c. Total contract price for Materials: _____
 - d. Type of Work performed: _____
5. Are the officers/partners/owners excluded from coverage? YES NO
 - a. If no, are payroll figures included above?

 Signature

 Title