STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 WEST STATE STREET, 3rd FLOOR
PO BOX 83720
BOISE, ID 83720-0043

FOR DEPARTMENT USE ONLY	
0560	
1025	
1315-10	
TOTAL	

STATEMENT OF TAXES AND FEES

REGISTERED SELF-FUNDED HEALTH CARE PLANS

PLAN/TRUST NAME		REGISTRATION NO.	
REPORTING ENTITY NAME		YEAR END DATE OF PLAN	
REPORTING ENTITY MAILING ADDRESS	CITY	STATE	ZIP CODE

RECAP OF TAXES AND FEES

NUMBER OF BENEFICIARIES COVERED PER MONTH:

Year	Month	Beneficiaries		Year	Month	Beneficiaries
	January				July	
	February				August	
	March				September	
	April				October	
	May				November	
	June				December	
					Total Beneficiars:	

1. TOTAL TAXES = TOTAL BENEFICIARIES_____ X .04 $_____

2. ANNUAL CONTINUATION FEE IDAPA 18.01.44.020.03.a.viii. IDAHO CODE 41 - 4011(3) 500.00
   Payment of fee must be included.

3. BALANCE DUE – Make check payable to: **Idaho Department of Insurance** $_____
   There will be a $20.00 charge on all returned checks. Idaho Code § 28-22-105
   Your canceled check is your receipt.

By my signature below, being duly sworn upon oath, I declare that the premium tax report is a complete, true and correct statement of all premiums and fees on business written by said company during the year ending December 31, 2016 on insurance of property or risks resident or locate in Idaho.

_____ _____
Contact person Signature of Officer (Required)

_____ _____
Telephone number Ext. Title

_____ _____
Email address Date