

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	_____

**2015 STATEMENT OF TAXES AND FEES
 HOSPITAL AND PROFESSIONAL SERVICE CORP.**

C/A NO.	NAIC NO.			
COMPANY NAME				FOR CALENDAR YEAR ENDING DECEMBER 31, 2015
MAILING ADDRESS	CITY	STATE	ZIP CODE	DOMICILE STATE

RECAP OF TAXES AND FEES

- 1. HOSPITAL AND PROFESSIONAL SERVICE CORPORATION TAX (SCHEDULE A) \$ _____
 - 2. TOTAL OF ALL ATTACHED SELF-FUNDED PLAN(S) TAX (SCHEDULE C) \$ _____
 - 3. ANNUAL CONTINUATION FEE for Calendar Year 2016, IDAPA 18.01.44.03.a.VI.: Payment of fee must be included. \$ 500.00
 - 4. ADD PENALTY, IF DUE (\$25.00 per day of delinquency - Idaho Code § 41-3928 and 41-3427) \$ _____
 - 5. TOTAL AMOUNT ENCLOSED: \$ _____
 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
- Indicate if payment is by EFT _____.

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, 2015 on insurance of property or risks resident or located in Idaho.

 Contact person

 Signature of Officer (required)

 Telephone number Ext.

 Title

 Email address
 INS-PTX-THPSC (10-15)
 Page 1 of 3

 Date

SCHEDULE A - HOSPITAL AND PROFESSIONAL SERVICE CORPORATIONS

TOTAL PREMIUMS WRITTEN

Use Health Annual Statement, Schedule T, Line 13, sum of Columns 2, 3, 4, 5.
 Exhibit of Premiums, Enrollment and Utilization – State Page.

NET SUBSCRIBERS' (MEMBER) CONTRACTS IN FORCE PER MONTH:

	<u>Members</u>	<u>Subscribers</u>		<u>Members</u>	<u>Subscribers</u>
JANUARY	_____	_____	JULY	_____	_____
FEBRUARY	_____	_____	AUGUST	_____	_____
MARCH	_____	_____	SEPTEMBER	_____	_____
APRIL	_____	_____	OCTOBER	_____	_____
MAY	_____	_____	NOVEMBER	_____	_____
JUNE	_____	_____	DECEMBER	_____	_____
			TOTALS	_____	_____

X \$.04 =

TOTAL TAX DUE ON SUBSCRIBERS \$ _____

Carry forward to Page 1, Recap of Taxes and Fees, Line 1

SCHEDULE C – EACH INDIVIDUAL SELF FUNDED PLANS

*** Submit a Schedule C for EACH administered self-funded plan**

NAME OF ADMINISTERED PLAN: _____

ADDRESS: _____ CITY: _____

NAME OF CONTACT PERSON: _____

NUMBER OF BENEFICIARIES COVERED PER MONTH: Idaho Code § 41-4012

JANUARY _____ JULY _____

FEBRUARY _____ AUGUST _____

MARCH _____ SEPTEMBER _____

APRIL _____ OCTOBER _____

MAY _____ NOVEMBER _____

JUNE _____ DECEMBER _____

TOTAL BENEFICIARIES _____

X \$.04 =

TOTAL TAX DUE \$ _____

Add each to total reported on Page 1, Recap of Taxes and Fees, Line 2