

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

FOR DEPARTMENT USE ONLY 0560

**SELF-FUNDED HEALTH CARE PLANS
 STATEMENT OF BACK TAXES DUE**

PLAN/TRUST NAME	REGISTRATION NO.
REPORTING ENTITY NAME	YEAR END DATE OF PLAN
REPORTING ENTITY MAILING ADDRESS	

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	
					Beneficiaries	

1. TOTAL TAXES = TOTAL BENEFICIARIES _____ X .04 \$ _____
2. BALANCE DUE - Make check payable to: **Idaho Department of Insurance**
 Your canceled check is your receipt. \$ _____
 There will be a \$20.00 charge on all returned checks. Idaho Code § 28-22-105

By my signature below, being duly sworn upon oath, I declare that I am authorized to represent, and do represent, that this tax statement is true, correct, and complete, and was prepared under my supervision. Statement must be duly sworn to by two executive officers that all premiums received with respect to insurance subject to resident, located or performed in Idaho.

 Contact person

 Signature of Company Officer

 Telephone number Ext.

 Printed name

 Email address

 Title

 Date