

FOR DEPARTMENT USE ONLY	
0560	
1025	
1315-10	_____
TOTAL	_____

2015 STATEMENT OF PREMIUM TAXES AND FEES
LIFE, ACCIDENT AND HEALTH COMPANIES

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. TOTAL TAXES DUE (Page 7, Schedule E, Line 6, GREATER of Column A or Column B) \$ _____
2. LESS PREMIUM GA TAX CREDIT (Page 6, Schedule 8, Line 3A,) \$ _____
3. LESS 2015 PREPAYMENTS REMITTED: (1) JUNE 15 \$ _____
 (2) SEPT. 15 \$ _____
 (3) DEC. 15 \$ _____ \$ _____
4. TAX SUBTOTAL - Line 1 less Line 2 and Line 3. If negative amount, also enter on Line 8. \$ _____
5. ANNUAL CONTINUATION FEE for Calendar Year 2016
ANNUAL STATEMENT PAGE 3, LINE 37, used to determine fee amount.

Surplus less than \$10,000,000	\$1,000.00
Surplus greater than \$10,000,000 but less than \$100,000,000	\$2,500.00
Surplus greater than \$100,000,000	\$4,500.00

Payment of continuation fee must be included.
 Do not use overpayment of tax on Line 4.

\$ _____
6. PLUS PENALTY, IF DUE (\$25.00 per day from postmark delinquency. Idaho Code § 41-404) \$ _____
7. AMOUNT ENCLOSED – ADD Lines 5 and 6. Include Line 4 if not a negative amount.
 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 _____
8. REFUND DUE FOR TAX OVERPAYMENT ONLY \$ _____

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

 Telephone number Ext.

 Email address

 Signature of Officer (required)

 Title

 Date

SCHEDULE A - COMPUTATION OF PREMIUM TAX - LIFE

TOTAL ANNUITY PREMIUMS (For information only) \$ _____

1. TOTAL LIFE PREMIUMS RECEIVED (including membership and policy fees)
 This amount must agree with the Annual Statement Idaho Business Page 24, Line 1 Column 5. \$ _____

A. Total premiums written through Associations, Trusts or Groups that are sited in a state other than Idaho but are for residents or risks located in Idaho and have been reported on Schedule T as premiums written in a state other than Idaho.
Idaho Tax Law does not allow the Rule of 500 to apply to tax obligation. \$ _____
 Must enter an amount even if zero

B. TOTAL PREMIUMS (Add Line 1, plus Line 1A) \$ _____

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from SUPPLEMENT 1 - Life Business in Jurisdictions not Licensed. \$ _____

3. LESS POLICY DIVIDENDS & RETURN COUPONS (If allocated as premium payments or paid-up additions, amount must be included in premium income shown on Line 1.)
 Cannot exceed the Annual Statement Idaho Business Page amounts or include dividends on exempt premiums reported in Line 4. \$ _____

4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:

TYPE OF PREEMPTION/EXEMPTION	PREMIUMS
A. U.S. INTERNAL REVENUE CODE <u>Sec. 401(a), 403, 404, 408, 501(a)</u>	\$ _____
B. _____	\$ _____
C. _____	\$ _____

TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4C) \$ _____

5. NET TAXABLE LIFE PREMIUMS (Line 1B + Line 2 - Line 3 - Line 4)
 Carry forward to Page 7, Schedule E, Line 1, Column A. \$ _____

6. PREMIUM TAX – 1.50% of Line 5.
 Carry forward to Page 7, Schedule E, Line 1B, Column A \$ _____

SCHEDULE B - COMPUTATION OF PREMIUM TAX - ACCIDENT AND HEALTH

1. TOTAL ACCIDENT AND HEALTH PREMIUMS (including policy, membership, installment and similar fees), LESS RETURN PREMIUMS ON POLICIES NOT TAKEN.
 This amount must agree with the Annual Statement Schedule T and Idaho Business Page 24, Column 1. \$ _____

A. Total premiums written through Associations, Trusts or Groups that are sited in a state other than Idaho but are for residents or risks located in Idaho and have been reported on Schedule T as premiums written in a state other than Idaho. \$ _____
Idaho Tax Law does not allow the Rule of 500 to apply to tax obligation. Must enter an amount even if zero

B. TOTAL PREMIUMS (Add Line 1, plus Line 1A) \$ _____

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from SUPPLEMENT 2 - Accident and Health Business in Jurisdictions not Licensed. \$ _____

3. LESS DIVIDENDS PAID OR CREDITED ON DIRECT BUSINESS.
 (If allocated as premium payments, amount must be included in premium income shown on Line 1). Cannot exceed the Annual Statement Idaho Business Page or include dividends on exempt premiums reported in Line 4. \$ _____

4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:

TYPE OF PREEMPTION/EXEMPTION	PREMIUMS
A. <u>Federal Employers Health Care</u>	\$ _____
B. <u>Federal Medicare Title XVIII</u>	\$ _____
C. <u>Dental Premiums (per Schedule D)</u>	\$ _____
D. _____	\$ _____

TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4D) \$ _____

5. NET TAXABLE ACCIDENT AND HEALTH PREMIUMS (Line 1B + Line 2 - Line 3 - Line 4)
 Carry forward to Page 7, Schedule E, Line 2, Column A. \$ _____

6. PREMIUM TAX – 1.50% of Line 5
 Carry forward to Page 7, Schedule E, Line 2B, Column A. \$ _____

SCHEDULE C – EACH INDIVIDUAL SELF FUNDED PLAN

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

PREPARE SEPARATE SCHEDULE C FOR EACH SELF FUNDED PLAN SUBJECT TO REGULATION UNDER TITLE 41 CHAPTER 40 IDAHO CODE. (SEE INSTRUCTIONS FOR ADDITIONAL INFORMATION)

NAME OF ADMINISTERED PLAN: _____

ADDRESS: _____ CITY: _____

NAME OF CONTACT PERSON: _____

PHONE _____

E-MAIL ADDRESS _____

NUMBER OF BENEFICIARIES COVERED PER MONTH:

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 7, Column A, Line 5 – OTHER TAXES

SCHEDULE D – DENTAL PLANS

Idaho Code 41-402(9)

TOTAL PREMIUMS FOR THE YEAR, ALSO REPORT ON PAGE 3, Line 4C _____

* EACH INDIVIDUAL INSURED, GROUP CERTIFICATE HOLDER, OR BLANKET POLICY PARTICIPANT PER MONTH

JANUARY	_____	JULY	_____
FEBRUARY	_____	AUGUST	_____
MARCH	_____	SEPTEMBER	_____
APRIL	_____	OCTOBER	_____
MAY	_____	NOVEMBER	_____
JUNE	_____	DECEMBER	_____

* TOTAL CONTRACTS _____

X \$.04 =

TOTAL TAX DUE \$ _____

ADD to total reported on Page 7, Column A, Line 5 – OTHER TAXES

SCHEDULE 8 – TAX CREDIT

CLASS B ASSESSMENT (Assessed in 2011) IDAHO LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION CREDIT

1. 2011 Class B Consolidated Health Assessment (ASSESSED 09/26/2011)

A. Maximum of 20% of Portion Paid in 2011 (Expires with Tax Due 03/01/2016)

Insert this total on Page 1, Line 2.

\$ _____

2. 2015 Class B National States Insurance Company Insolvency Assessment (Effective 7/28/2015)

A. Maximum of 20% of Portion Paid in 2015 (Expires with Tax Due 03/01/2020)

\$ _____

3. Total of 2011 Class B and 2015 Class B Assessment

A. Insert this total on Page 1, Line 2.

\$ _____

NOTE: ITEMIZE ONLY THE ACTUAL CREDIT BEING TAKEN FOR EACH ASSESSMENT. DO NOT REPORT ORIGINAL AMOUNTS PAID OR BALANCES REMAINING ON ASSESSMENTS.

NOTE: YOUR COMPANY MAY TAKE ONLY 20% OF THE CREDIT IN EACH OF THE FIVE YEARS FOLLOWING THE CALENDAR YEAR IN WHICH THE ASSESSMENT WAS PAID. IF YOUR COMPANY DOES NOT TAKE THE 20% IN THE YEAR IT IS AVAILABLE, IT WILL LOSE THAT 20%.

SCHEDULE E - COMPUTATION OF RETALIATORY TAXES

MUST BE INCLUDED WITH RETURN

Idaho Code § 41-340 (2) and (3)

<u>NET PREMIUMS SUBJECT TO TAX:</u>	Column A AMOUNT PAID IN IDAHO	Column B AMOUNT WOULD PAY IN DOMICILE STATE
1. LIFE PREMIUMS	\$ _____	\$ _____
A. PREMIUM TAX RATE	_____ 1.50% _____	_____
B. PREMIUM TAX (Line 1 x Line 1A)	\$ _____ •	\$ _____ •
2. ACCIDENT AND HEALTH PREMIUMS	\$ _____	\$ _____
A. PREMIUM TAX RATE	_____ 1.50% _____	_____
B. PREMIUM TAX (Line 2 x Line 2A)	\$ _____ •	\$ _____ •
3. ANNUITY PREMIUMS	XXXXXXXXXXXXXXXXXXXXXX	\$ _____
A. ANNUITY TAX RATE	XXXXXXXXXXXXXXXXXXXXXX	_____
B. ANNUITY TAX (Line 3 x Line 3A)	XXXXXXXXXXXXXXXXXXXXXX	\$ _____ •
4. MUNICIPAL, CITY OR COUNTY PREMIUMS	XXXXXXXXXXXXXXXXXXXXXX	\$ _____
A. MUNICIPAL, CITY OR COUNTY TAX RATE	XXXXXXXXXXXXXXXXXXXXXX	_____
B. MUNICIPAL, CITY OR COUNTY TAX (Line 4 x Line 4A)	XXXXXXXXXXXXXXXXXXXXXX	\$ _____ •
5. OTHER TAXES - Identify Each:		
<u>SELF-FUNDED PLANS (Schedule C)</u>	\$ _____	\$ _____ •
<u>DENTAL PLANS (Schedule D)</u>	\$ _____	\$ _____ •
_____	\$ _____	\$ _____ •
_____	\$ _____	\$ _____ •
6. TOTAL TAXES (Lines 1B+2B+3B+4B+5) Carry GREATER AMOUNT of Column A or B forward to Page 1, Recap of Taxes, Line 1	\$ _____	\$ _____