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

Under penalty of perjury, I declare that this statement (including any accompanying schedules and statements) has been examined by me and to the best of my knowledge and belief is a true, correct, and complete return.

Contact Person

Signature of Officer Date

( )
Telephone Number Ext.

Name (Type or Print)

E-Mail Address

Title

INS-PTX-TBKSFHP (10-11)