

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 <hr/> TOTAL
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**STATEMENT OF PREMIUM TAXES AND FEES  
 INSURER'S USING ANNUAL STATEMENT HEALTH BLANK**

C/A NO.	NAIC NO.		
COMPANY NAME		FOR CALENDAR YEAR ENDING DECEMBER 31, 2008	
MAILING ADDRESS		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 TOTAL WORKERS COMENSATION TAX CREDIT (Schedule 7, Line 6) \$ \_\_\_\_\_
3. LESS 2008 PREPAYMENTS REMITTED: (1) JUNE 15 \$ \_\_\_\_\_  
 (2) SEPT. 15 \$ \_\_\_\_\_  
 (3) DEC. 15 \$ \_\_\_\_\_ \$ \_\_\_\_\_
4. TAX SUBTOTAL - Line 1 less Lines 2 and 3. If negative amount, also enter on Line 8. \$ \_\_\_\_\_
5. ANNUAL CONTINUATION FEE for Calendar Year 2009.  
**MUST ATTACH ANNUAL STATEMENT PAGE 3, LINE 31, COLUMN 3** is 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 \$ \_\_\_\_\_

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 statement.

\_\_\_\_\_  
 Contact Person  
 ( )  
 \_\_\_\_\_  
 Telephone Number Ext.

\_\_\_\_\_  
 Signature of Officer Date  
 \_\_\_\_\_  
 Name and Title (Type or Print)

**SCHEDULE A - COMPUTATION OF PREMIUM TAX ACCIDENT AND HEALTH ONLY**

1. TOTAL HEALTH PREMIUMS (including membership and policy, installment and similar fees). LESS return premiums on policies not taken. This amount must agree with the ATTACHED Schedule T, Line 13, Column 2 Exhibit of Premiums, Enrollment and Utilization, Line 12, Column 1. Report premiums for ALL Idaho residents, **Idaho DOES NOT allow the Rule of 500 exemption.** \$ \_\_\_\_\_

2. IDAHO DOMESTIC INSURERS - Enter total premiums from attached tax SUPPLEMENT 1 - Business in Jurisdictions not Licensed. \$ \_\_\_\_\_

3. 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</u> (per Schedule D)	\$ _____
D. _____	\$ _____

TOTAL EXEMPT PREMIUMS (Add Lines 3A through 3D) \$ \_\_\_\_\_

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

5. PREMIUM TAX – 1.90% (1.46%) of Line 4  
Carry forward to Page 7, Schedule E, Line 1B, Column A.  
If qualified for the 1.46% reduced tax rate under Idaho Code § 41-403,  
You must complete and attach Pages 8 and 9, Schedule F. \$ \_\_\_\_\_

**RETALIATORY SCHEDULE E MUST BE COMPLETED.**

**↔ COPIES OF THE ANNUAL STATEMENT MUST BE INCLUDED FOR VERIFICATION**

**SCHEDULE T,  
EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION STATE OF IDAHO.**

## SCHEDULE B1 - COMPUTATION OF PREMIUM TAX - LIFE

1. TOTAL LIFE PREMIUMS DIRECT (including membership and policy fees)  
 This amount must agree with the ATTACHED Schedule T, Column 6, Line 13 and Supplement 28, Direct Business in the State of Idaho, Column 5.  
 Report premiums for ALL Idaho residents, **Idaho DOES NOT allow the Rule of 500 exemption.** \$ \_\_\_\_\_

A. TOTAL ANNUITY PREMIUMS (For information only) \$ \_\_\_\_\_

2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from attached tax 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 ATTACHED 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.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 1 + Line 2 - Line 3 - Line 4)  
 Carry forward to Page 7, Schedule E, Line 2, Column A. \$ \_\_\_\_\_

6. PREMIUM TAX – 1.90% (1.46%) of Line 5.  
 Carry forward to Page 7, Schedule E, Line 2B, Column A.  
 If qualified for the 1.46% reduced tax rate under Idaho Code § 41-403, you must complete and attach Page 8 and 9, Schedule F. \$ \_\_\_\_\_

**RETALIATORY SCHEDULE E MUST BE COMPLETED.**

↔ **COPIES OF THE ANNUAL STATEMENT MUST BE INCLUDED FOR VERIFICATION**  
**SCHEDULE T**  
**SUPPLEMENT 28 - DIRECT BUSINESS IN THE STATE OF IDAHO**

**SCHEDULE B2 - COMPUTATION OF PREMIUM TAX - PROPERTY AND CASUALTY**

1. TOTAL DIRECT PREMIUMS WRITTEN PLUS SERVICE OR FINANCE CHARGES (including policy, membership, installment and similar fees), LESS return premiums on policies not taken. This amount must agree with the ATTACHED Schedule T, Column 7, Line 13 and Supplement 64, Exhibit of Premium and Losses State of Idaho. Report ALL Idaho premiums, **Idaho DOES NOT allow the Rule of 500 exemption** \$ \_\_\_\_\_
2. IDAHO DOMESTIC INSURERS - Enter total premiums minus dividends from attached tax SUPPLEMENT 1 - Business in Jurisdictions not Licensed. \$ \_\_\_\_\_
3. LESS DIVIDENDS PAID OR CREDITED TO THE ACCOUNT OF POLICYHOLDERS. Must agree with ATTACHED Annual Statement Idaho Business Page and Schedule T, excluding accident and health dividends. \$ \_\_\_\_\_
4. PREMIUMS EXEMPT AND/OR PREEMPTED BY FEDERAL LAW:
- | TYPE OF PREEMPTION/EXEMPTION                    | PREMIUMS |
|---|----------|
| A. <u>Multiple Peril Crop</u>                   | \$ _____ |
| B. <u>Federal Flood</u>                         | \$ _____ |
| C. _____  | \$ _____ |
| TOTAL EXEMPT PREMIUMS (Add Lines 4A through 4C) | \$ _____ |
5. NET TAXABLE PROPERTY AND CASUALTY PREMIUMS (Line 1 + Line 2 - Line 3 - Line 4) Carry forward to Page 7, Schedule E, Line 3, Column A. \$ \_\_\_\_\_
6. PREMIUM TAX – 1.90% (1.46%) of Line 5. (Report negative amounts.) Carry forward to Page 7, Schedule E, Line 3B, Column A. If qualified for the 1.46% reduced tax rate under Idaho Code § 41-403, you must complete and attach Page 8 and 9, Schedule F. \$ \_\_\_\_\_

**RETALIATORY SCHEDULE E MUST BE COMPLETED.**

↔ **COPIES OF THE ANNUAL STATEMENT MUST BE INCLUDED FOR VERIFICATION**  
**SCHEDULE T,**  
**SUPPLEMENT 64 - EXHIBIT OF PREMIUMS AND LOSSES - STATE OF IDAHO**

## 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 OR 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, Line 5, Column A – OTHER TAXES

## SCHEDULE D – DENTAL PLANS

Idaho Code 41-402 (9) change effective July 1, 2007

TOTAL DENTAL PREMIUMS FOR THE YEAR, ALSO REPORT ON PAGE 2, Line 3C \_\_\_\_\_

**\*** 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 each to total reported on Page 7, Column A, Line 5 – OTHER TAXES

## SCHEDULE E- COMPUTATION OF RETALIATORY TAXES

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. SCHEDULE A - ACCIDENT AND HEALTH PREMIUMS	\$ _____	\$ _____
A. PREMIUM TAX RATE	_____ 1.90% or 1.46% _____	_____
B. PREMIUM TAX (Line 1 x Line 1A)	\$ _____	\$ _____
2. SCHEDULE B1 - LIFE PREMIUMS	\$ _____	\$ _____
A. PREMIUM TAX RATE	_____ 1.90% or 1.46% _____	_____
B. PREMIUM TAX (Line 2 x Line 2A)	\$ _____	\$ _____
3. SCHEDULE B2 - PROPERTY AND CASUALTY PREMIUMS	\$ _____	\$ _____
A. PREMIUM TAX RATE	_____ 1.90% or 1.46% _____	_____
B. PREMIUM TAX (Line 3 x Line 3A)	\$ _____	\$ _____
4. MUNICIPAL, CITY OR COUNTY PREMIUMS	XXXXXXXXXXXXXXXXXXXXXXX	\$ _____
A. MUNICIPAL, CITY OR COUNTY TAX RATE	XXXXXXXXXXXXXXXXXXXXXXX	_____
B. MUNICIPAL, CITY OR COUNTY TAX (Line 4 x Line 4A)	XXXXXXXXXXXXXXXXXXXXXXX	\$ _____
5. OTHER TAXES – Identify Each:		
<u>SELF-FUNDED PLANS (Schedule C)</u>	\$ _____	\$ _____
<u>DENTAL PLANS (Schedule D)</u>	\$ _____	\$ _____
_____	\$ _____	\$ _____
6. TOTAL TAXES (ADD Lines 1B THRU 5) Carry GREATER AMOUNT of Column A or B Forward to Page 1, Recap of Taxes, Line 1	\$ _____	\$ _____

**SCHEDULE F- QUALIFICATION FOR REDUCED PREMIUM TAX**

Idaho Code § 41-403

**Complete, sign and attach, only if you are requesting the reduced tax rate.**

**An itemized schedule must be attached showing qualified investment descriptions, amounts, types, inception and maturity dates for each Idaho investment; and must agree with amounts reported on Annual Statement, Page 2 as Net Admitted Assets in Column 3 .**

**Reduced Tax Qualification for Year Ending December 31, 2008**

Public Obligations	\$ _____
Corporate Bonds	\$ _____
Preferred Stock	\$ _____
Common Stock	\$ _____
Mortgage Loans	\$ _____
Real Estate	\$ _____
Time Deposits	\$ _____
Other (Explain) _____	\$ _____
<b>TOTAL QUALIFYING IDAHO INVESTMENTS</b>	<b>\$ _____</b>

**IF** licensed for LIFE: Enter Total Required Reserves  
(ATTACH Annual Statement, Page 3, Column 3, Line 4 + Line 5) \$ \_\_\_\_\_

Percentage of Qualifying Idaho Investments to Required Reserves \_\_\_\_\_%

\* OR \*

**IF** licensed for OTHER THAN LIFE: Enter Total Net Admitted Assets  
(ATTACH Annual Statement, Page 2, Column 3, Line 26) \$ \_\_\_\_\_

Percentage of Qualifying Idaho Investments to Admitted Assets \_\_\_\_\_%

**NOTE:** Qualification for the reduced premium tax rate (1.46% or retaliatory rate, whichever is greater) shall be in strict conformity with the provisions of Idaho Code § 41-403, and the computation for qualification made hereon shall be subject to examination and review by the Department of Insurance.

I hereby certify that the investments listed herein are qualifying Idaho investments as provided by Idaho Code § 41-403, and that the company, as shown above, has qualified at all times throughout the year for the reduced premium tax rate.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (Type or print)

**MONTHLY TOTALS REQUIRED FOR  
QUALIFYING IDAHO INVESTMENTS**

	<b>TOTAL REQUIRED RESERVES OR ADMITTED ASSETS</b>	<b>TOTAL QUALIFIED IDAHO INVESTMENTS</b>	<b>PERCENTAGE RATIO</b>
Per Annual Statement Prior Year's Balance December 31, 2007	\$ _____	\$ _____	_____
January	\$ _____	\$ _____	_____
February	\$ _____	\$ _____	_____
March	\$ _____	\$ _____	_____
April	\$ _____	\$ _____	_____
May	\$ _____	\$ _____	_____
June	\$ _____	\$ _____	_____
July	\$ _____	\$ _____	_____
August	\$ _____	\$ _____	_____
September	\$ _____	\$ _____	_____
October	\$ _____	\$ _____	_____
November	\$ _____	\$ _____	_____
December 31, 2008	\$ _____	\$ _____	_____