

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

FOR DEPARTMENT USE ONLY	0560	
	1315-10	_____
	TOTAL	_____

**STATEMENT OF MONTHLY PREMIUM TAXES
 PURCHASING GROUPS**

PURCHASING GROUP OFFICIAL NAME	
MAILING ADDRESS	DOMICILE STATE

CALCULATION OF PREMIUM TAX

This tax statement must be completed within thirty (30) days of procurement of insurance. **Delinquent filing and payment of taxes subject insured to a penalty of 6% per annum, compounded annually.** Idaho Code § 41-4816, 41-1233 and 41-4810.

DO NOT USE THIS FORM IF COVERAGE IS WITH A SURPLUS LINES COMPANY/BROKER.

INSURER'S NAME _____

INSURER'S ADDRESS _____

TYPE OF POLICY _____

NAME & LOCATION OF RISK INSURED _____

EFFECTIVE DATES OF POLICY _____



**ATTACH DOCUMENTATION WHICH VERIFIES
 THE AUTHENTICITY OF THE INFORMATION**

- 1. PREMIUM WRITTEN ON POLICY \$ _____
- 2. MULTIPLY LINE 1 BY THE IDAHO TAX RATE for 2009 OF 1.7% _____
- 3. PLUS PENALTY, IF DUE _____
- 4. TOTAL AMOUNT DUE \$ _____

Make your 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.

Under penalty of perjury, I declare that this statement has been examined by me and to the best of my knowledge is a true, correct, and complete statement.

 Contact Person
 ()

 Telephone Number Ext.

 Signature Date

 Name and Title (Type or Print)