

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
TOTAL	_____

STATEMENT OF TAXES AND FEES
HOSPITAL AND PROFESSIONAL SERVICE CORP.

C/A NO.	NAIC NO.
COMPANY NAME	FOR CALENDAR YEAR ENDING DECEMBER 31, 2011
MAILING ADDRESS	DOMICILE STATE

RECAP OF TAXES AND FEES

1. HOSPITAL AND PROFESSIONAL SERVICE CORPORATION TAX (SCHEDULE A) \$ _____
2. TOTAL OF ALL ATTACHED SELF-FUNDED PLAN(S) TAX (SCHEDULE C) \$ _____
3. ANNUAL CONTINUATION FEE for Calendar Year 2012, IDAPA 18.01.44.03.a.Vi.: Payment of fee must be included. \$ 500.00
4. ADD PENALTY, IF DUE (\$25.00 per day of delinquency - Idaho Code § 41-3928 and 41-3427) \$ _____
5. TOTAL AMOUNT ENCLOSED: \$ _____
 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 _____.

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	_____ Name (Type or Print)	
_____ E-mail Address	_____ Title	

SCHEDULE A - HOSPITAL AND PROFESSIONAL SERVICE CORPORATIONS

TOTAL PREMIUMS WRITTEN

Use Annual Statement, Schedule T, Line 13, sum of Columns 2, 3, 4, 5.

NET SUBSCRIBERS' (MEMBER) CONTRACTS IN FORCE PER MONTH:

	<u>Members</u>	<u>Subscribers</u>		<u>Members</u>	<u>Subscribers</u>
JANUARY	_____	_____	JULY	_____	_____
FEBRUARY	_____	_____	AUGUST	_____	_____
MARCH	_____	_____	SEPTEMBER	_____	_____
APRIL	_____	_____	OCTOBER	_____	_____
MAY	_____	_____	NOVEMBER	_____	_____
JUNE	_____	_____	DECEMBER	_____	_____
			TOTALS	_____	_____

X \$.04 =

TOTAL TAX DUE ON SUBSCRIBERS \$ _____

Carry forward to Page 1, Recap of Taxes and Fees, Line 1

SCHEDULE C – EACH INDIVIDUAL SELF FUNDED PLANS

*** Submit a Schedule C for EACH administered self-funded plan**

NAME OF ADMINISTERED PLAN: _____

ADDRESS: _____ CITY: _____

NAME OF CONTACT PERSON: _____

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

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 1, Recap of Taxes and Fees, Line 2