STATE OF DELAWARE
DEPARTMENT OF INSURANCE
Surplus Lines Monthly Report

Month: _____

Broker Name: _____

EIN # or SSN: _____ Phone #: _____

Address: _____

E-mail: _____

Named Insured	Location	Effective Date	Term	Company	Policy Number	Type of Coverage	% of Total	Gross Premium	Tax Amount Due

TOTAL TAX DUE:

SUMMARY:

(Premium totals based on location of risk)

COUNTY	FIRE PREMIUM	OTHER PREMIUM
Sussex		
Kent		
New Castle		
City of Wilmington		