STATE OF DELAWARE DEPARTMENT OF INSURANCE
PREMIUM TAX AND FEES REPORT
FOR THE CALENDAR YEAR 2003, DUE MARCH 1, 2004

Original Report ☐
Amended Report ☐

FOREIGN

TAX DEPARTMENT MAILING ADDRESS AND COMPANY INFORMATION

Company Name:
Premium Tax Contact Person:
Contact E-mail:
Tax Dept. Phone and Ext.: **Fax:**
Tax Department Address:
City – State – Country – Zip + 4:

Federal E.I.N. #:
N.A.I.C. #:
N.A.I.C. Group #:
State of Domicile (abbr.):

Has this Company written any Wet Marine and Transportation insurance in the United States in any of the past 3 years? **(Check one)**
Yes ☐ **No** ☐

IMPORTANT: If Company Name, Employer Identification Number (EIN), NAIC Number, NAIC Group, or any other Company Information changed during the year; you must complete the Historical Information Section on Page 4.

If this address or any other Company information changed during the calendar year, Check this Box ➔ ☐

Was payment for these taxes and/or fees sent electronically via ACH Credit? (Check one) **Yes** ☐ **No** ☐

NOTE: Authorization Agreement approval required for ACH Credit Option

If claiming overpayment on Line 20, Check this Box ➔ ☐
IMPORTANT: If claiming overpayment, DO NOT apply overpayment amount to quarterly tax liability. The State of Delaware will issue a refund check to Company.

$
Pay amount listed on Line 19.
Make check payable to "Delaware Insurance Dept."

PREMIUM TAX SUMMARY FOR CALENDAR YEAR 2003

GROSS DIRECT PREMIUM INCOME
Must equal data reported on State Business Page (Statutory Page 14) of Annual Statement

1.	Life Premiums	$	1
2.	Accident and Health Premiums	$	2
3.	Property, Casualty, Surety and Title Premiums	$	3
4.	Worker's Compensation / Employer's Liability Premiums	$	4
5.	TOTAL – All Gross Direct Premium Income	$	5
6.	Premium Tax Rate (2%)	X .02	6
7.	TOTAL Premium Tax eligible for Guaranty Fund Assessment Credit	$	7
8.	LESS: Life & Health Insurance Guaranty Fund Assessment Credit	$ ( )	8
9.	LESS: Property & Casualty Insurance Guaranty Fund Assessment Credit	$ ( )	9
	IMPORTANT: Guaranty Fund Credits may not reduce premium tax liability to less than zero.		
10.	NET Premium Tax Due (Line 7 less Line 8 and/or Line 9) **Tax liability may not be < $0.00. If less than "0", enter "0".**	$	10

OTHER TAXES, FEES AND/OR CREDITS

11.	Domestic Insurer's Privilege Tax	$ NOT APPLICABLE	11
12.	Foreign Insurer's Retaliatory Tax and Fees	$	12
13.	Employer/Trust Owned Life Insurance Premium Tax	$	13
14.	Annual Continuation Fees (a) Certificate of Authority / Renewal Fee **(RRGs enter $50.00)**	$ 100.00	14
	(b) Annual Statement Filing	$ 100.00	14
15.	Delaware Insurance Fraud Prevention Bureau Annual Fee	$ 550.00	15
16.	Credit Due from Travelink Program	$ ( )	16
17.	TOTAL Taxes, Fees and/or Credits Due (Lines 10 thru 16)	$	17
18.	LESS: Quarterly Tax Prepayments		
	a) April 15, 2003 $		
	b) June 15, 2003 $		
	c) September 15, 2003 $		
	d) December 15, 2003 $		
	e) TOTAL Prepaid during 2003 (Sum Lines 18a thru 18d)	$ ( )	18
19.	NET AMOUNT DUE **Attach payment for this amount.** ➔	$	19
20.	REFUND **IMPORTANT:** A Refund Check will be sent to the Company. DO NOT apply this amount to future tax liability. ➔	$( )	20

FOREIGN INSURERS' RETALIATORY TAX AND FEES INSTRUCTIONS

Lines 1-3	List types and volumes of taxable premiums of insurance written in Delaware (as reported on Annual Statement State Page) at the applicable tax rate that your State of Domicile (Home State) would charge a Delaware domiciled insurer doing similar business in that state. Different types of insurance with the same tax rate may be combined and listed on one line. **Include all finance and service charges.** **DO NOT INCLUDE EMPLOYER/TRUST OWNED LIFE INSURANCE PREMIUM IN AMOUNTS LISTED ON LINES 1-3.** Employer/Trust Owned Life Insurance written in accordance with 18 Del. C., §2704(e) qualifies for exemption to retaliatory action as permitted in 18 Del. C., §532(b).
Line 4	Workmen's Compensation/Employer's Liability premiums. **Note:** Workmen's Compensation premiums MUST be recorded separately on Line 4 (not combined and listed with other insurance).
Lines 5-8	List Home State annual fees as applicable.
Line 9	List number of new agents appointed in DE during calendar year. Multiply by Home State's appointment fee **(list fee amount).**
Lines 10-11	List any and all miscellaneous annual fees that a Delaware domiciled company, writing similar lines and volumes of business would be assessed on an annual basis in your Home State. **Please describe and list each fee type separately.**
Line 12	Home State Total – Sum Lines 1 through 11.
Line 13	Delaware Net Premium Tax taken from Page 1, Premium Tax Summary, Line 7.
Lines 14-15	Delaware annual Continuation Fees taken from Page 1, Premium Tax Summary, Lines 14(a) and (b). **DO NOT INCLUDE $550.00 FRAUD FEE**

IMPORTANT: *The Delaware Insurance Department considers the Fraud Prevention Bureau Fee to be a Special Purpose Assessment and does not allow the fee amount paid to the State to be included in retaliatory tax calculation.* ***(See*** www.state.de.us/inscom ***for more information)***

Line 16	Use the same number of new agents as listed in Line 9. Multiply by $25.00 for Delaware basis calculation.
Line 17	Delaware Total – Sum Lines 13 through 16. Subtract this amount from the Home State Total amount on Line 12.
Line 18	**NET Retaliatory Tax** due to Delaware. Enter this amount on Page 1, Premium Tax Summary, Line 12. **If "0", or less than "0", enter "0".**

RETALIATORY TAXES AND FEES TAX CALCULATION

HOME STATE TAXES AND FEES

List State of Domicile (Home State): _____

	TYPE OF INSURANCE	PREMIUMS	TAX RATE	AMOUNT		
1.		$	@ %	$		1
2.		$	@ %	$		2
3.		$	@ %	$		3
4.	Worker's Compensation	$	@ %	$		4
5.	Certificate of Authority Renewal			$		5
6.	Annual Statement Filing Fee			$		6
7.	Annual Statement Abstract Fee			$		7
8.	Annual Statement Publication Fee			$		8
	New Agent's Initial Appointments in Delaware during calendar year:					
9.	TOTAL # Agents _____ @ Home State Fee of $ _____			$		9
10.				$		10
11.				$		11
12.	HOME STATE TOTAL (Sum of Lines 1 through 11)				$	12

LESS DELAWARE TAXES AND FEES

13.	Premium Tax		$		13
14.	Certificate of Authority Renewal		$		14
15.	Annual Statement Filing Fee		$		15
	New Agent's Initial Appointments in Delaware during calendar year:				
16.	TOTAL # Agents _____ @ Delaware Fee of **$ 25.00**		$		16
17.	DELAWARE TOTAL (Sum of Lines 13 through 16)		(–)	$	17
18.	TOTAL Retaliatory Tax Amount Due (Line 12 minus Line 17)		Enter this amount on Page 1, Premium Tax Summary, Line 12	$	18

REPORT OF GROSS PREMIUMS FOR STATE SUPPORT OF FIRE COMPANIES, AMBULANCE AND RESCUE ORGANIZATIONS

➢➢➢ THIS IS NOT A TAX ⮜⮜⮜

As with all forms in this tax report, the President and Secretary verify its accuracy and completeness.

- **Every company receiving premiums for insurance coverage in Delaware under the property and casualty lines listed, must complete Part I and Part II of this report. (18 Del. C., §705(a))**
- **Every company receiving premiums for life, accident or health insurance coverage of all types in Delaware must complete Part III of this report. (18 Del. C., §713)**
- **The State uses this information to determine the amount of financial support that volunteer fire companies and nonprofit ambulance and rescue services providers receive from the State.**

INSTRUCTIONS

PART I: Copy corresponding line number figures from State Page [Exhibit Of Premiums And Losses (Statutory Page 14 Data)], Page 26, Column 2.

PART II: Each insurer MUST show what portion of the total gross direct premiums listed in PART I is allocable to each of the four geographical sub-divisions within the state of Delaware. Allocations are to be determined by **location of risk.**

PART III: Line 1: Enter corresponding Delaware figure from Schedule T (page 67), Column 2.
Line 2: Enter amount listed on Page 4, WF T-8 Summary Form, Line 3
Line 3: Enter corresponding Delaware figure from Schedule T (page 67), Column 4.

STATE SUPPORT OF FIRE COMPANIES
Based on Property and Casualty Premiums Written as Reported on State Page

PART I GROSS DIRECT PREMIUMS, LESS RETURN PREMIUMS BY LINE OF AUTHORITY

1.	Fire	$	1
2.1.	Allied Lines	$	2.1
2.2.	Multiple Peril Crop	$	2.2
2.3.	Federal Flood	$	2.3
3.	Farmowners Multiple Peril	$	3
4.	Homeowners Multiple Peril	$	4
5.1.	Commercial Multiple Peril (non-liability portion)	$	5.1
8.	Ocean Marine (other than Wet Marine & Transportation)	$	8
9.	Inland Marine (other than Wet Marine & Transportation)	$	9
12.	Earthquake	$	12
21.1.	Private Passenger Auto Physical Damage	$	21.1
21.2.	Commercial Auto Physical Damage	$	21.2
22.	Aircraft (all perils)	$	22
	TOTAL	$	T

PART II PREMIUM DISTRIBUTION BY LOCATION OF RISK

City of Wilmington		$	W
New Castle County (outside City of Wilmington)		$	NC
Kent County		$	K
Sussex County		$	S
PART I TOTAL MUST EQUAL PART II TOTAL	**TOTAL**	$	T

STATE SUPPORT OF AMBULANCE AND RESCUE ORGANIZATIONS
Based on Life, Accident and Health Premiums Written as Reported on Schedule T

PART III ALL GROSS DIRECT PREMIUMS

1.	Life (Do Not include Annuities)	$	1
2.	Employer/Trust Owned Life Insurance (Sum Total Delaware Premiums for all Cases)	$	2
3.	Accident and Health	$	3
	TOTAL	$	T

TRAVELINK PROGRAM TAX CREDIT FORM

See Title 30, Del. C., §2030 ET SEQ for details.

As used in this section, TC is the amount of Tax Credit; CTG is the number of commuter trips generated, defined herein as the annualized number of employees reporting and departing from the place of employment during the peak travel periods; CTR is the number of commuter trip reductions, defined herein as the number of employees participating in a Delaware Department of Transportation Certified Travelink Program for at least 30 days of the applicable tax year; and DC is the employer's allowable direct costs. The credit granted under this law shall be the product of either equation described below; whichever is less. **Enter the amount from either Line 1 OR Line 2 on Page 1, Premium Tax Summary Form, Line 16.**

1. TC + (CTR/CTG) x DC **OR** $ _____
2. TC + CTR x $250 $ _____

EMPLOYER OWNED/TRUST OWNED LIFE INSURANCE WF T-8 SUMMARY FORM

Only companies writing this type of business as defined in 18 Del. C., §2704 should complete Working Form T-8. Complete Working Form T-8 for each case. Sum the amounts from all cases for Lines 2, 5, and 6 on Working Form T-8 and transfer the total amounts from each Line to this Form.

1. TOTAL NUMBER OF CASES _____
2. TOTAL PREMIUM AMOUNT (Sum Line 2 for all cases) $ _____
3. TOTAL DELAWARE PREMIUM AMOUNT (Sum Line 5 for all cases) **Enter this amount on Page 4, Part III, Line 2 ➔** $ _____
4. TOTAL PREMIUM TAX DUE (Sum Line 6 from all cases) **Enter this amount on Page 1, Premium Tax Summary, Line 13 ➔** $ _____

COMPANY HISTORICAL INFORMATION

Complete All Applicable Sections ONLY If There Was A Change During Calendar Year 2003.

1. Effective ____/____/____, the Insurer received **NEW** authorization to do business in the State of Delaware.
2. Effective ____/____/____, the Insurer changed its **STATE OF DOMICILE** from the state of: _____ to the state of: _____
3. Effective ____/____/____, the Insurer changed its **NAME** from its former name of: _____
4. Effective ____/____/____, the Insurer changed its **E.I.N.** from: _____ to: _____
5. Effective ____/____/____, the Insurer changed its **N.A.I.C. #** from: _____ to: _____
6. Effective ____/____/____, the Insurer **acquired** Delaware business by way of *(circle one)* **Merger** or **Assumption Agreement** with another Insurer known as _____ NAIC #: _____
7. Effective ____/____/____, the Insurer **ceded** essentially all Delaware business by way of *(circle one)* **Merger** or **Assumption Agreement** with another Insurer known as _____ NAIC #: _____ And further *(Check one)* _____ Remains an insurance corporation admitted in Delaware **OR** _____ Has surrendered its Delaware Certificate of Authority

➢➢➢ ALL COMPANIES MUST COMPLETE THIS SECTION ⮜⮜⮜

AFFIDAVIT In accordance with 18 Del. C., §702 (a), the Premium Tax and Fees Report shall be verified by the oath or affirmation of the president or secretary or other responsible officer of the insurer, duly administered by a person authorized to administer oaths.

STATE of _____, COUNTY of _____, on this _____ day of _____ 2004, before me, the subscriber, personally appeared _____ (PRESIDENT), and _____ (SECRETARY) of the above named Insurer who being duly sworn (or affirmed) deposes and says that this report and all schedules are true, correct, and complete.

_____ _____
Company Officer Signature ***Title***

_____ _____
Company Officer Signature ***Title*** *(Company Seal)*

If signed by Company Officer other than President or Secretary, state reason: _____

SWORN TO (OR AFFIRMED) AND SUBSCRIBED BEFORE ME THE DAY AND YEAR AFORESAID.

_____ _____
Signature (Notary Public) Date Commission Expires *(Notary Seal)*

EMPLOYER OWNED / TRUST OWNED LIFE INSURANCE
(Also Known As "COLI" and/or "BOLI", etc. Premiums)
WORKING FORM T-8

ANY COMPANY WRITING THIS TYPE OF BUSINESS AS DEFINED IN 18 Del. C., §2704 MUST COMPLETE THIS FORM

➢➢➢ ALL OTHER COMPANIES — DO NOT RETURN THIS PAGE ⮜⮜⮜

Complete this form for each Employer/Trust Owned Life Insurance Case. After completion, sum the amounts from Line 2, Line 5, and Line 6 for all cases and transfer the total amounts from each Line to the WF T-8 Summary Form on Page 4. If company has more cases, reproduce this Working Form or use a similar format and attach additional pages as needed.

1. Case Name: _____ Case #: _____
2. Total Premium for this Case $ _____
3. Net Premium for risks located in Delaware $ _____
4. Net Premium for risks resident or located outside Delaware for which premium tax is not paid to the State of residency or location. $ _____
5. Total DELAWARE Premium Amount for Calendar Year $ _____

	PREMIUM AMOUNT		TAX RATE		TAX AMOUNT
TAX CALCULATION:	$	@	2%	=	$
	$	@	1.5%	=	$
	$	@	1.25%	=	$
	$	@	1%	=	$

6. **TOTAL Tax Due This Case** $ _____

1. Case Name: _____ Case #: _____
2. Total Premium for this Case $ _____
3. Net Premium for risks located in Delaware $ _____
4. Net Premium for risks resident or located outside Delaware for which premium tax is not paid to the State of residency or location. $ _____
5. Total DELAWARE Premium Amount for Calendar Year $ _____

	PREMIUM AMOUNT		TAX RATE		TAX AMOUNT
TAX CALCULATION:	$	@	2%	=	$
	$	@	1.5%	=	$
	$	@	1.25%	=	$
	$	@	1%	=	$

6. **TOTAL Tax Due This Case** $ _____

1. Case Name: _____ Case #: _____
2. Total Premium for this Case $ _____
3. Net Premium for risks located in Delaware $ _____
4. Net Premium for risks resident or located outside Delaware for which premium tax is not paid to the State of residency or location. $ _____
5. Total DELAWARE Premium Amount for Calendar Year $ _____

	PREMIUM AMOUNT		TAX RATE		TAX AMOUNT
TAX CALCULATION:	$	@	2%	=	$
	$	@	1.5%	=	$
	$	@	1.25%	=	$
	$	@	1%	=	$

6. **TOTAL Tax Due This Case** $ _____

➢ Each case must be reported. This Form may be reproduced. Attach additional pages as needed. ⮜