

**CALENDAR YEAR 2015
MARYLAND INSURANCE ADMINISTRATION**

ANNUAL PREMIUM TAX STATEMENT

TAX REMITTANCE STATEMENT

Company NAIC #:

Company Name:

Address:

| | <u>SOURCE</u> | <u>FUND</u> | <u>DESCRIPTION</u> | <u>AMOUNT DUE AND REMITTED</u> |
|----|---------------|-------------|--------------------|------------------------------------|
| 1. | 3396 | 1000 | Total Tax Due | 0.00 |

Form Filing

Preferred filing of completed form is in pdf format attachment via email to: (2015premiumtaxfiling.mia@maryland.gov.)

If filing by mail or courier please address it to:

2015 Premium Tax
Maryland Insurance Administration
Attn: Fiscal-Stop #100
200 Saint Paul Place, Suite 2700
Baltimore, Maryland 21202

Payment

- Check mailed to Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202-2272 Attention: Fiscal – Stop # 100. To ensure proper credit, please complete the Payment Voucher contained in this form and include your NAIC number on the check. If paying for multiple companies in one check, please list separately NAIC number and amount for each company.
- Payment sent by ACH credit or wire (for instructions email: fiscalserv.mia@maryland.gov) and attach Premium Tax Annual Payment Voucher to your Annual Premium Tax Statement
- No payment or refund due.
- Refund owed. \$ _____ (If Line 10 of the Payment Calculation Form is negative.)

The officers - _____ Title i.e., President, and _____ Title i.e., Vice-President
- Name of this reporting entity – _____ I.e., _____

I _____ (officer #1) do solemnly affirm under the penalties of perjury that this Tax Remittance Statement has been examined by me and is to the best of my knowledge, information and belief, a true and complete return made in good faith for the taxable year stated, pursuant to the existing laws of the State of Maryland. _____ (signature)

I _____ (officer #2) do solemnly affirm under the penalties of perjury that this Tax Remittance Statement has been examined by me and is to the best of my knowledge, information and belief, a true and complete return made in good faith for the taxable year stated, pursuant to the existing laws of the State of Maryland. _____ (signature)

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Name, Title, Phone Number, Email Address and Fax Number of the person/s responsible for the completion of this statement:

| Name | Title | Phone Number | Email Address | Fax Number |
|------|-------|--------------|---------------|------------|
|------|-------|--------------|---------------|------------|

List of required documents to be submitted to the Maryland Insurance Administration to support tax filing:

For Foreign and Domestic Companies

- Check with **copy of Tax Remittance Statement** (if box for Check Mailed on Tax Remittance Statement is selected).
- Job Creation Tax Credit - (Schedule A, Line A1) (if claiming credit).
- Credit for Wages, Child Care, and Transportation for Employee with Disabilities - (Schedule A, Line A2) (if claiming credit).
- Credit for New or Expanded Business Premises - (Schedule A, Line A3) (if claiming credit).
- Credit for Long-Term Care Insurance - (Schedule A, Line A4) (if claiming credit).
- Tax Credit for Wages Paid Under Work-Based Learning Program - (Schedule A, Line A5) (if claiming credit).
- Credits for One Maryland Start-up Costs - (Schedule A, Line A6) (if claiming credit).
- Credits for Costs of Commuter Benefits - (Schedule A, Line A7) (if claiming credit).
- Tax Credit for Investment of Designated Capital - (Schedule A, Line A8) (if claiming credit).
- Sustainable Communities Credit (Previously called Heritage Structure Rehabilitation) - (Schedule A, Line A9) (if claiming credit).

For Maryland Domestic Companies Only

- Insurance Regulation Fund (provided by domestic companies only, if claiming credit).
- Health Regulatory Fund (provided by domestic companies only, if claiming credit).
- Maryland Home Office Retaliatory Tax Credit Section 6-104(c) of the Insurance Article, Annotated Code of Maryland of the Insurance Article (Schedule A, Line A10) (if claiming credit)

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ANNUAL PREMIUM TAX STATEMENT

PAYMENT CALCULATION FORM

Employer's I.D. Number: NAIC # - Company Name

If correction was made to EIN, check the box.

The purpose of this form is to reconcile the estimated prepayment tax (due April 15, June 15, September 15 and December 15) with the total tax and retaliatory amount owed the Maryland Insurance Administration. (DO NOT ENTER NEGATIVE AMOUNT ON LINES 1, 3 OR 12).

Check if prepopulated prepayments are modified.

- 1. Gross Premium Tax Due (From Line 5 of Page 4).....\$

- 2. Credit(s) for 2015 (From Line A11 of Page 7)

- 3. Net Premium Tax Due (Line 1 less Line 2, but not less than \$0).

- 4. Prepayments during last calendar year:

- 5. Prior Year Carry Forward Credit / Overpayment

- 6. April 15, 2015.....Payment.....

- 7. June 15, 2015Payment.....

- 8. September 15, 2015..... Payment.....

- 9. December 15, 2015 Payment.....

- 10. **Total Prepaid**\$

- 11. Balance Due or Overpayment (Line 3 minus Line 10) [+ or (-)].....\$

- 12. Retaliatory Amount due (From Line 28 of Retaliatory Summary Sheet).....\$

- 13. **TOTAL OF LINES 11 and 12**.....\$

The amount shown in the Line 13 above carries to Line 1 of Annual Premium Tax Statement's Page Number 1 if positive or zero. If negative, this amount carries as positive number to the space following "Refund Owed" checkbox.

If the total on Line 13 is a positive amount, payment should be remitted by the taxpayer using the payment form elected on page i of the Annual Premium Tax Remittance Statement. If a paper check is remitted, it must be made payable to "Maryland Insurance Administration Premium Tax" and must be accompanied by a copy of the Annual Premium Tax Statement. If the total on Line 13 is a negative amount, the MIA will issue a refund. All forms will be audited. If adjustments are made, you will be immediately notified.

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ANNUAL PREMIUM TAX STATEMENT

The following is a full and complete statement of all premiums and other consideration received by

Enter NAIC # - COMPANY NAME

of **Enter City , State Name** , on risks allocated or located in the State of Maryland, during the calendar year ending December 31, 2015.

- 1. Total premiums (From Premiums Exhibit, Line PE10)\$
- 2. Total deductions (From Deductions Exhibit, Line DE13)\$
- 3. Total taxable premiums (Line 1 less Line 2, but not less than \$0)\$
- 4. Tax rate (authorized insurers use 2.00%. Unauthorized insurers use 3.00%.) 2.00%
3.00%
- 5. Tax (Line 3 multiplied by Line 4) (Note that the amount entered here should also be the amount entered on Line 3, Column 2 of the Retaliatory Summary Sheet for non-domestic companies)\$

| |
|--|
| |
| |

**CALENDAR YEAR 2015
MARYLAND INSURANCE ADMINISTRATION**

ANNUAL PREMIUM TAX STATEMENT

PREMIUMS EXHIBIT

NAIC # - COMPANY NAME: 00000 – *Company Name*

LIFE AND HEALTH INSURERS / HEALTH MAINTENANCE ORGANIZATIONS

| | | | |
|-------|--|-----------|------------|
| PE1. | Life insurance premiums of life insurance companies as shown on Line 1, Column 5 of the Direct Business Page for Maryland | \$ | .00 |
| PE2. | Deposit-type contract funds of life insurance companies as shown on Line 3, Column 5 of the Direct Business Page for Maryland | \$ | .00 |
| PE2a. | Annuity considerations of life insurance companies as shown on Line 2, Column 5 of the Direct Business Page for Maryland | \$ | .00 |
| PE3. | Other considerations of life insurance companies as shown on Line 4, Column 5 of the Direct Business Page for Maryland..... | \$ | .00 |
| PE4. | Accident and health insurance premiums of life insurance companies as shown on Line 26, Column 1 of the Direct Business Page for Maryland; and nonprofit health service plan corporations; and health maintenance organizations as shown on Line 12, Column 1 of the Direct Business Page for Maryland | \$ | .00 |
| PE5. | All other premiums, assessments and charges not previously shown above on Lines PE1 through PE5..... | \$ | .00 |
| PE6. | Total (Lines PE1 through PE5)..... | \$ | .00 |

PROPERTY AND CASUALTY INSURERS / RISK RETENTION GROUPS / TITLE COMPANIES

| | | | |
|------|---|-----------|------------|
| PE7. | Direct premiums on all risks written (Column 1 in the NAIC's Annual Statement Exhibit of Premiums and Losses) (Statutory Page 14 Data) | \$ | .00 |
| PE8. | All other taxable premiums received, finance, service or other carrying charges not included (in Lines 1 to 32 as reported in the NAIC's Annual Statement Exhibit of Premiums and Losses (Statutory Page 14 Data))..... | \$ | .00 |
| PE9. | Total (Lines PE7 through PE8)..... | \$ | .00 |

| | | | |
|-------|--|-----------|------------|
| PE10. | Total premiums (Line PE6 or Line PE9 depending on company type) | \$ | .00 |
| | Carry this amount to Annual Premium Tax Statement, Line 1 | | |

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ANNUAL PREMIUM TAX STATEMENT

DEDUCTIONS EXHIBIT

NAIC # COMPANY 00000 – Company Name
NAME:

LIFE AND HEALTH INSURERS / HEALTH MAINTENANCE ORGANIZATIONS

| | | |
|------|--|------------|
| DE1. | Premiums received for group medical, surgical, hospital or any other remedial care from a certified small employer health benefit plan.....\$ | .00 |
| DE2. | Premiums received for any federal or state programs (Federal Employee Health Benefits, Medicare, Medicaid, etc.) exempt from taxation. Do not include any amounts for which deductions are shown on Line DE1\$ | .00 |
| DE3. | Premiums received for Medicare Part D prescription drug plans that are exempt from taxation should be included here, separate from DE2.\$ | .00 |
| DE4. | Premiums received in connection with the funding of a pension, deferred compensation, annuity or profit-sharing plan qualified or exempt under Sections 401, 403, 404, 408, 457 or 501 of the U.S. Internal Revenue Code. Do not include any amounts for which deductions are shown above on Lines DE1 through DE3\$ | .00 |
| DE5. | Premiums received for reinsurance from any other company authorized to do business in Maryland.....\$ | .00 |
| DE6. | Premiums returned on account of cancellations. Do not include surrender values.....\$ | .00 |
| DE7. | Dividends returned. Do not include any amounts for which deductions are shown above on Lines DE1 through DE6 *\$ | .00 |
| DE8. | All other deductions not shown above on Lines DE1 through DE7 (attach documentation to support).....\$ | .00 |
| DE9. | Total (Lines DE1 through DE8)\$ | .00 |

PROPERTY AND CASUALTY INSURERS / RISK RETENTION GROUPS / TITLE COMPANIES

| | | |
|-------|---|------------|
| DE10. | Dividends paid (Col 3 of Exhibit of Premiums and Losses) (Statutory Page 14 Data)\$ | .00 |
| DE11. | Other deductions (attach documentation to support).....\$ | .00 |
| DE12. | Total (Lines DE10 through DE11)\$ | .00 |

| | | |
|-------|---|-------------|
| DE13. | Total deductions (Line DE9 or Line DE12 depending on company type)\$ Carry this amount to Annual Premium Tax Statement, Line 2 | 0.00 |
|-------|---|-------------|

*** Do not deduct dividends that are used to purchase additional insurance for policyholders.**

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ANNUAL PREMIUM TAX STATEMENT

SCHEDULE A - CREDIT SUMMARY

COMPANY NAME: 00000 – *Company Name*

All forms and documentation for any credit taken must be attached.

| Foreign and Domestic Companies | | | |
|---------------------------------------|---|----|-----|
| A1. | Job Creation Tax Credit | \$ | .00 |
| | Refer to Section 6-114 of the Insurance Article, Annotated Code of Maryland. An insurer may claim credit against the premium tax for wages paid to qualified employees under Title 6, Subtitle 3 of the Economic Development Article. | | |
| A2. | Credits for Wages, Child Care, and Transpiration for Employee with Disabilities | \$ | .00 |
| | Refer to Section 6-115 of the Insurance Article, Annotated Code of Maryland. Section 21-309 of the Education Article. | | |
| A3. | Credit for New or Expanded Business Premises | \$ | .00 |
| | Refer to Section 6-116 of the Insurance Article, Annotated Code of Maryland. Provided under Section 9-230 of the Tax-Property Article. | | |
| A4. | Credit for Long-Term Care Insurance | \$ | .00 |
| | Refer to Section 6-117 of the Insurance Article, Annotated Code of Maryland. Provided under Section 10-710 of the Tax-General Article. | | |
| A5. | Tax Credit for Wages Paid Under Work-Based Learning Program | \$ | .00 |
| | Refer to Section 6-118 of the Insurance Article, Annotated Code of Maryland. Provided under Section 21-501 of the Education Article. Abrogated on 06/30/2013. | | |
| A6. | Credits for One Maryland Start-up Costs | \$ | .00 |
| | Refer to Section 6-119 of the Insurance Article, Annotated Code of Maryland. Provided under Title 6, Subtitle 4 of the Economic Development Article. | | |
| A7. | Credits for Costs of Commuter Benefits | \$ | .00 |
| | Refer to Section 6-120 of the Insurance Article, Annotated Code of Maryland. Provided under Section 2-901 of the Environmental Article. | | |
| A8. | Tax Credit for Investment of Designated Capital | \$ | .00 |
| | Refer to Section 6-122 of the Insurance Article, Annotated Code of Maryland. | | |
| A9. | Sustainable Communities Credit (Previously called Heritage Structure Rehabilitation) | \$ | .00 |
| | Refer to Section 6-105.2 of the Insurance Article, Annotated Code of Maryland. Provide under Section 5A-303 of the State Finance & Procurement Article. | | |
| Domestic Companies Only | | | |
| A10. | Maryland Home Office Retaliatory Tax Credit | | .00 |
| | Refer to Section 6-104(c) of the Insurance Article, Annotated Code of Maryland of the Insurance Article. | | |
| A11. | Total Credits (Lines A1 through A 10) | \$ | .00 |
| | Carry this amount to Annual Premium Tax Statement, Page 1 Line 6 | | |

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ANNUAL PREMIUM TAX STATEMENT

SCHEDULE B – RETALIATORY PREMIUM TAX WORKSHEET

NAME OF COMPANY: 00000 – *Company Name*

Complete this form ONLY if your state of domicile has a tax rate different from Maryland's 2.0% rate, or if your company's state of domicile has varying tax rates based on premium volume or line of business.

B1. Maryland total taxable premiums (from Annual Premium Tax Statement Line 3) \$.00

B2. Instructions: Enter a description, a premium dollar amount and the tax rate for each different tax rate charged in the Company's home/domiciliary state. The Total Premium on Line k must be equal to the value in B1.

| | Type of Premium | Amount | Rate | Tax |
|----|------------------------|---------------|-------------|------------|
| a) | | \$.00 | | \$.00 |
| b) | | \$.00 | | \$.00 |
| c) | | \$.00 | | \$.00 |
| d) | | \$.00 | | \$.00 |
| e) | | \$.00 | | \$.00 |
| f) | | \$.00 | | \$.00 |
| g) | | \$.00 | | \$.00 |
| h) | | \$.00 | | \$.00 |
| i) | | \$.00 | | \$.00 |
| j) | | \$.00 | | \$.00 |

k) **Total Premium:** \$.00

B3. **Company's Home State Basis Tax Total (Sum of the Tax Column)** \$.00
Carry this amount to Retaliatory Summary Sheet Line 3 Column 3

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INSTRUCTIONS FOR COMPLETING THE RETALIATORY SUMMARY SHEET

0000 – Company Name

1. The items listed in Column (1), lines 2, 3, 4, 10, and 11 are the charges and payments imposed by the laws of Maryland. Each company is required to enter the amounts of all charges due or payments made to Maryland in Column (2).
2. Amounts to be entered in Column (3) for lines 1 through 10 must be based on charges and payments which would have been payable by a similar Maryland-domiciled company doing business in your company's home state. Lines 11 through 24 are provided for your company to enter charges and payments required of a Maryland company doing business in your company's home state that are not included in items on lines 1 through 10.
3. Lines 5, 6, 7, 8a, 8b, 9a and 9b of Column (2) will all be zero. Maryland does not charge companies for these fees. Column (3) for each of these lines must include the total amount that a company would pay based upon the same number of certifications and renewals issued in Maryland but using the fees assessed by your company's state of domicile. You must include amounts in these four fields for fees paid in your company's state of domicile.

It is the company's responsibility to make certain that all items required of a Maryland insurance company doing business in your home state are listed in Column (1) and the corresponding charges or payments are entered in Column (3) of this Retaliatory Summary Sheet. A proper and complete retaliatory computation is required under Title 6, Subtitle 3 of the Insurance Article, Annotated Code of Maryland, and by COMAR 31.06.02. Additional information may be requested from the company and/or from its home state to verify the computation.

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RETALIATORY SUMMARY SHEET

00000 - *Company Name*

| | (1) | (2) Maryland Basis (What you paid to Maryland) | (3) Company's Home State Basis For Maryland Companies |
|--|--|---|---|
| 1. | Annual Statement Filing Fee | | .00 |
| 2. | Certificate of Authority | .00 | .00 |
| 3. | Premium Tax (From Annual Premium Tax Statement, Line 5) | .00 | .00 |
| 4. | Insurance Regulation Fund (Fee Fund Assessment) | .00 | .00 |
| 5. | Renewal Fee | .00 | .00 |
| 6. | Firefighters Relief Fund Tax | | .00 |
| 7. | Fire Marshal Tax | | .00 |
| 8a. | Resident Agent Certification Fees *** (paid by company) | | .00 |
| 8b. | Nonresident Agent Certification Fees *** (paid by company) | | .00 |
| 9a. | Resident Agency Certification Fees *** (paid by company) | | .00 |
| 9b. | Nonresident Agency Certification Fees *** (paid by company) | | .00 |
| 10. | Fraud Prevention Fee | .00 | .00 |
| 11. | Health Care Regulatory Fund Assessment | .00 | .00 |
| 12. | Ocean (Wet) Marine Profit Tax | .00 | .00 |
| 13. | | | .00 |
| 14. | | | .00 |
| 15. | | | .00 |
| 16. | | | .00 |
| 17. | | | .00 |
| 18. | | | .00 |
| 19. | | | .00 |
| 20. | | | .00 |
| 21. | | | .00 |
| 22. | | | .00 |
| 23. | | | .00 |
| 24. | | | .00 |
| 25. | TOTALS | .00 | .00 |
| COMPUTATION OF RETALIATORY AMOUNTS OWED TO MARYLAND | | | |
| 26. | Amount shown on line 25, Column (3) | | .00 |
| 27. | Amount shown on line 25, Column (2) | | .00 |
| 28. | TOTAL Retaliatory amount due (Line 26 less Line 27, but not less than \$0). Note: that the amount entered here should also be the amount entered on Line 9 of the Payment Calculation Form. | | .00 |

*** If you pay Agent or Agency Certification Fees in your home state, you must include your Home State Basis fees here. Refer to Instruction Number 3 above.

**CALENDAR YEAR 2015
MARYLAND INSURANCE ADMINISTRATION**

ANNUAL PREMIUM TAX STATEMENT

SUPPLEMENTAL FILING FORM

**Health Care Regulatory Fund Assessment and
Insurance Regulation Fund Assessment**

Company NAIC No:

Company Tax ID:

Company Name: _____

Instructions:

The information on this form is used to determine both the Insurance Regulation Fund Assessment and the Health Care Regulatory Fund Assessment. Entering incorrect or no information could result in a company being incorrectly assessed. Therefore, it is important for a carrier to accurately complete this form.

=> **All carriers licensed in Maryland must complete Section A.**

=> **All carriers issuing health insurance in Maryland must complete Section B.**

Section A: Gross Direct Written Premiums

| | | |
|---|-----------|------------|
| 1) Health Insurance Premiums | \$ | .00 |
| 2) Annuity and Life Insurance Premiums | \$ | .00 |
| 3) Property and Casualty Insurance Premiums | \$ | .00 |
| A: Total Premiums Written in Maryland | \$ | .00 |

Section B: Exclusions for Health Care Regulatory Assessment [see Insurance Article 2-112.2(a)(3)(ii)]

| | | |
|---|----|-----|
| 1) Long-term Care Insurance..... | \$ | .00 |
| 2) Disability Insurance..... | \$ | .00 |
| 3) Accidental Travel; Accidental Death and Dismemberment Insurance..... | \$ | .00 |
| 4) Credit Health Insurance..... | \$ | .00 |
| 5) Any insurance for which payment of benefits is conditioned on a determination of medical necessity made solely by the treating health care provider not acting on behalf of the carrier. (You must specify the type of insurance for which you are claiming the exclusion.)..... | | |
| a) _____ | \$ | .00 |
| b) _____ | \$ | .00 |
| c) _____ | \$ | .00 |
| SUBTOTAL | \$ | .00 |
| 6) Any other insurance for which payment of benefits is not conditioned on a determination of medical necessity (You must specify the type of insurance for which you are claiming the exclusion, e.g., Medicare supplemental) | | |
| a) _____ | \$ | .00 |
| b) _____ | \$ | .00 |
| c) _____ | \$ | .00 |
| SUBTOTAL | \$ | .00 |

**CALENDAR YEAR 2015
MARYLAND INSURANCE ADMINISTRATION**

**ANNUAL PREMIUM TAX STATEMENT
SUPPLEMENTAL FILING FORM**

**Health Care Regulatory Fund Assessment and
Insurance Regulation Fund Assessment**

0000 - *Company Name*

| | | | |
|-----|--|----|-----|
| 7) | A health benefit plan issued by a Managed Care Organization.. (You must specify the type of health benefit plan for which you are claiming the exclusion)..... | \$ | .00 |
| 8) | Other (Please specify the type of insurance for which you are claiming the exclusion.) | | |
| | a) _____ | \$ | .00 |
| | b) _____ | \$ | .00 |
| | c) _____ | \$ | .00 |
| | d) _____ | \$ | .00 |
| | e) _____ | \$ | .00 |
| | SUBTOTAL | \$ | .00 |
| 9) | Medicare..... | \$ | .00 |
| 10) | Medicare Part D..... | \$ | .00 |
| 11) | Non-Risk Business..... | \$ | .00 |
| 12) | Federal Employees Health Benefit Plans..... | \$ | .00 |
| | Total Exclusions (Add items B1 through B12)..... | \$ | .00 |
| | Total Health Insurance Premiums Subject to the Health Regulatory Assessment (Section A less Section B Total Exclusions)..... | \$ | .00 |

Contact Name: _____ **Contact Telephone No:** _____

Contact Title: _____

Certification: By submitting this form you certify that the above-referenced information is accurate and complete.