**Section 2515.ILLUSTRATION A Annual Privilege and Retaliatory Tax Return**

|  |  |
| --- | --- |
|  | **Illinois Department of Insurance** |
|  | **320 W. Washington Street** |
|  | **State of Illinois** | **Springfield, IL 62767-0001** |
| **1998 Privilege and Retaliatory Tax Statement for Property and Casualty Insurers** |
| **Business during the Calendar Year 1998** | **Due: March 15, 1999** |
|  |
| Federal Employer Identification Number: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ NAIC: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_ |
|  |  |  |
| Name of Insurance Company |
| with principal office located at |  |  |
|  | Street and Number | City | State | Zip Code |
| incorporated under the laws of the State of |  | as required by and in |
| accordance with “215 ILCS 5/410” of the Illinois Compiled Statutes. |
| Mailing address, if other than principal office location shown above |  |  |
|  |  |  |
| Contact person: |  | Phone ( ) |  |  |
|  |
| **Instructions** |
|  | **Important Notice:** The FEIN must be on this statement to ensure proper posting to your company account. |
| 1 | The Privilege and Retaliatory Tax Statement must be filed and the taxes due must be paid on or before March 15, 1999. **The official filing date is the U.S. Postal date.** |
| 2 | Separate checks and statement is requested for each company of an insurance group. |
| 3 | The Department of Insurance cannot issue cash refunds of overpayments. Overpayments should be applied to all future privilege and retaliatory tax liabilities only. |
| 4 | No authority exists for granting any extension of time for filing or payment. |
| 5 | The payment received will be subject to audit and subsequent adjustments if necessary. |
| 6 | Any penalties to be levied will be assessed as provided by “215 ILCS 5/412,” Illinois Compiled Statutes. |
| 7 | File only one original notarized copy. The Illinois Department of Insurance will not accept computerized, fax or any facsimile tax statements. Companies must use the prescribed form furnished by the Department. Failure to do so will subject your company to penalties per "215 ILCS 5/412” of the Illinois Compiled Statutes. |
| 8 | Remittance should be made payable to the **Director of Insurance** and mailed with the completed tax statement to attention Tax and Fiscal Services Section, Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767-0001  |
| **Do not mail checks or forms with the Annual Statement.** |
| **Important Notice. Disclosure of this information is required under the Illinois Compiled Statutes’ Insurance Laws. Failure to provide this information will result in a fine. This form has been approved by the Forms Management Center.** |
| IL 446-0126-P | Printed on recycled paper |
| 1 of 6 |

|  |
| --- |
| NAIC Group Code \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ |
| NAIC Company Code \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ |
| **Direct Business in the State of Illinois During the Year 1998****Property & Casualty Insurance** |
|  | **Gross Premiums, Including Policy and Membership Fees, Less Return Premiums and Premiums on Policies Not Taken** | **Dividends Paid or Credited to Policyholders on Direct Business** |
| **Line of Business** | **Direct** **Premiums** **Written** | **Direct** **Premiums Earned** |
| 1. | Fire |  |  |  |
| 2.1 | Allied Lines |  |  |  |
| 2.2 | Multiple peril crop |  |  |  |
| 2.3 | Federal flood |  |  |  |
| 3. | Farmowners multiple peril  |  |  |  |
| 4. | Homeowners multiple peril |  |  |  |
| 5.1 | Commercial multiple peril (non-liability portion) |  |  |  |
| 5.2 | Commercial multiple peril (liability portion) |  |  |  |
| 6. | Mortgage guaranty |  |  |  |
| 8. | Ocean marine |  |  |  |
| 9. | Inland marine |  |  |  |
| 10. | Financial guaranty |  |  |  |
| 11. | Medical malpractice |  |  |  |
| 12. | Earthquake |  |  |  |
| 13. | Group accident and health |  |  |  |
| 14. | Credit A & H (Group and Individual) |  |  |  |
| 15.1 | Collectively renewable A & H |  |  |  |
| 15.2 | Non-cancellable A & H |  |  |  |
| 15.3 | Guaranteed renewable A & H |  |  |  |
| 15.4 | Non-renewable for stated reasons only |  |  |  |
| 15.5 | Other accident only |  |  |  |
| 15.6 | All other A & H |  |  |  |
| 15.7 | Federal employees health benefits program premium |  |  |  |
| 16. | Workers’ compensation |  |  |  |
| 17. | Other liability |  |  |  |
| 18. | Products liability  |  |  |  |
| 19.1 | Private passenger auto no-fault (personal injury protection) |  |  |  |
| 19.2 | Other private passenger auto liability |  |  |  |
| 19.3 | Commercial auto no-fault (personal injury protection) |  |  |  |
| 19.4 | Other commercial auto liability |  |  |  |
| 21.1 | Private passenger auto physical damage |  |  |  |
| 21.2 | Commercial auto physical damage |  |  |  |
| 22. | Aircraft (all perils) |  |  |  |
| 23. | Fidelity |  |  |  |
| 24. | Surety |  |  |  |
| 26. | Burglary and theft |  |  |  |
| 27. | Boiler and Machinery |  |  |  |
| 28.  | Credit |  |  |  |
| 31. | Aggregate write-ins for other lines of business |  |  |  |
| 32. | **Totals (a)** |  |  |  |
| 32a | Finance and service charges not included in Lines 1 to 32 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
|  |
| **Amounts Must Agree to Direct Business Page of Company’s Annual Statement.** |
| 2 of 6 |

|  |  |
| --- | --- |
|  | **Property and Casualty Insurance Companies** |
| **Privilege Tax Calculation** | **1****Premium** | **2****Premium Rate** | **3****Premium Tax** |
| 1. | Property and Casualty Insurance Premiums (Page 15 Column 2. Line 32 of the Annual Statement except Lines 13 thru 15.6 and other exempt lines of premium) |  |  |  |
| 2. | Finance and service charges as reported on Page 15 of the Annual Statement |  |  |  |
| 3. | DEDUCTIONS |  |  |  |
|  | Dividends paid or credited to policyholders on premiums reported on Line 1 (Page 15. Column 4 of the Annual Statement) |  |  |  |
| 4. | NET TAXABLE PROPERTY & CASUALTY PREMIUMS (Column 1. Line 1 plus 2 minus 3) |  |  |  |
| 5. | Property & Casualty Premium Tax (Column 1. Line 4 x Column 2) |  | .005 |  |
| 6. | Accident and Health Premiums (Page 15. Column 2. Lines 13 thru 15.6 per Rule 2510.50) (July 1 thru Dec 31 1998) |  |  |  |
| 7. | DEDUCTIONS |  |  |  |
|  | Dividends paid or credited to policyholders on premiums reported on Line 6 (Page 15. Column 4 of the Annual Statement) (July thru December 31, 1998) |  |  |  |
| 8. | NET TAXABLE ACCIDENT AND HEALTH PREMIUMS (Column 1. Line 6 minus Line 7) (July 1 thru Dec 31 1998) |  |  |  |
| 9. | Property & Casualty Accident & Health Premium Tax (Column 1. Line 8 x Column 2) |  | .004 |  |
| 10. | **Net Premium Tax Before Credits (Column 3. Line 5 plus Line 9)** |  |  |  |
|  | **Less Credits to the Privilege Tax** |  |  |  |
| 11. | FIRE DEPARTMENT TAXES PAID |  |  |  |
|  | 11a  | Fire Department Taxes paid to Illinois Municipal League |  |  |  |
|  | 11b | Fire Department Taxes-Other (Proof of Payment) |  |  |  |
|  | 11c | Total Fire Department Taxes (Col 1. Lines 11a plus 11 b) |  |  |  |
|  | CORPORATE & REPLACEMENT INCOME TAX INTERGRADATION EXCESS |  |  |  |
|  | Complete Lines 12 thru 13 if Corporate and Replacement Income Taxes are not paid on a Unitary Method. If paid on a Unitary Method, go to U-1 Schedule and complete as directed  |  |  |  |
| 12. | ILLINOIS CORPORATE INCOME TAX PAYMENTS |  |  |  |
|  | 12a | 1997 Final Payment |  |  |  |
|  | 12b | 1998 Total Quarterly Payments |  |  |  |
|  | 12c | Other Payments paid during Calender Year 1998 |  |  |  |
|  | 12d | Less State Income Tax Cash Refunds Received |  |  |  |
|  | 12e | TOTAL |  |  |  |
| 13. | ILLINOIS PERSONAL PROPERTY REPLACEMENT CORPORATE INCOME TAX PAYMENTS |  |  |  |
|  | 13a | 1997 Final Payment |  |  |  |
|  | 13b | 1998 Total Quarterly Payments |  |  |  |
|  | 13c | Other Payments paid during Calendar Year 1998 |  |  |  |
|  | 13d | Less Replacement State Income Tax Cash Refunds Received |  |  |  |
|  | 13e | TOTAL |  |  |  |
| 14. | TOTAL NET INCOME TAXES (12e plus 13e) |  |  |  |
| 15. | Unitary Member Income Tax Offset (Schedule U-1) |  |  |  |
| 16. | Total Property and Casualty Premium & Accident and Health Premium (Col 1. Line 4 plus Col 1. Line 8) |  |  |  |
| 17. | Intergradation Offset is excess of 1.5% Net Taxable Premium (Line 16 x 1.5%) |  |  |  |
| 18. | Intergradation Offset Amount (Line 14 or 15 minus Line 17) If negative enter zero |  |  |  |
| 19. | NET PREMIUM TAX (Line 10 less Line 11c less Line 18) (cannot be less than -0-) |  |  |  |
| 3 of 6 |

|  |
| --- |
| **Computation of Retaliatory Taxes** |
| Under “215 ILCS 5/444 and 5/444.1” of the Illinois Compiled Statutes, when the laws of any other state require of companies domiciled in Illinois the payment of penalties, fees, charges or taxes greater than those required in the aggregate for like purposes under the laws of Illinois by companies domiciled in such states, the Director of Insurance is required to impose comparable requirements on a retaliatory basis. All insurance related taxes and fees, including premium taxes, based on the State of Incorporation requirements, should be calculated below with the total carried forward to Page 6, Line 2 under Column 2.  |
| **Retaliatory Tax Calculation** | **Column 1** | **Column 2** |
| **State of Illinois Basis** | **State of Incorporation Basis** |
| 1 | Annual Statement Filing Fee | $100.00 |  |
| 2 | Certificate of Authority Fee | $100.00 |  |
| 3 | Fire Marshal Tax |  |  |
| 4 | Fire Department Tax (proof of payment must be attached) |  |  |
| 5 | Financial Regulation Fee |  |  |
| 6 | Policy Form Filing Fee |  |  |
| \*7a | Illinois Corporate & Replacement Income Taxes Paid |  | xxxxxxxxxxxxxx |
| 7b | Illinois Life & Health Guaranty Fund Credit (per Association's  |  | xxxxxxxxxxxxxx |
|  | official notice) |
| 7c | Other State of Illinois Taxes and Fees per Article XXV |  | xxxxxxxxxxxxxx |
| 7d | Other State of Incorporation Taxes and Fees | xxxxxxxxxxxxxx |  |
| 7e | State of Incorporation income tax paid without reduction, if any  | xxxxxxxxxxxxxx |  |
|  | is otherwise allowed, for a similar association offset as the Illinois Life and Health Guaranty Association per Section 2515.50(c)(5) |
| 8 | Privilege Premium Tax Franchise Tax, etc |  |  |
| 9 | Total Illinois Basis |  | xxxxxxxxxxxxxx |
| 10 | Total State of Incorporation Basis | xxxxxxxxxxxxxx |  |
| 11 | Total Retaliatory Tax Due (Line 10 minus Line 9: balance | xxxxxxxxxxxxxx |  |
|  | cannot be less than -0-). |
| **\*If Illinois Corporate and Replacement income taxes are paid on a unitary method, please complete Schedule U-1****in detail. Proof of Payment (cancelled checks and IL 1120) must be attached to verify basis.** |
| 4 of 6 |

|  |
| --- |
| **Income Tax Offset Based on Unitary Method of Corporate and Replacement Tax** |
| **Allocated by each Company’s Illinois Premium Written (including annuities)****to the Unitary Group’s Total Illinois Premium Written (Schedule U-1)** |
|  | **Identity** | **Payment** |  | **Refund** | **Results** |
|  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|  | **Company Name of Each Unitary Member** | **Company FEIN** | **Illinois Direct Premium** | **Percentage Allocation** | **Tax Offset Allocated by Percentage** | **Refund Offset Allocation by %** | **Allowed** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
| 15 | Column Totals |  |  |  |  |  |  |
| Taxes Paid By (Name of Company and the FEIN of Taxpayer)  |  |  |
|  |  |  |
| Total Taxes Paid  |  |  |
| Total Refund Issued  |  |  |
| Net Available for Offset  |  |  |
| (This amount will be verified per the Department of Revenue records.) |
|  |
| **Procedure to Determine the Income Tax Offset on the Unitary Method** |
| We will use Schedule U-1 to determine the income tax offset for companies using the Unitary Method. The allocation of the total income tax paid will be based on the Illinois premium written (including annuities) by each individual company as a percent of the Unitary group total. This allocation is multiplied to the unitary calendar year amount paid and the result is the available income tax offset for that individual company. |
| If the unitary group received a refund during the calendar year the refund must also be allocated among the individual companies. If a member of the unitary group received a refund during the calendar year the refund must be allocated among all members of the unitary group. Only the net amount is allowed. |
| Each unitary group must complete Schedule U-1 to be allowed the offset. Any unitary group that does **not** complete Schedule U-1 will not be allowed to use the Illinois Corporate and Replacement income taxes in the calculation of the privilege and retaliatory taxes. |
| 5 of 6 |

|  |  |  |
| --- | --- | --- |
| **Payment Summary** | **Column 1** | **Column 2** |
| 1 | Amount due as Privilege Tax (Line 19. Page 3) |  |  |
| 2 | Amount due as Retaliatory Tax (Line 11. Page 4) |  |  |
| 3 | Total Privilege and Retaliatory Tax (Line 1 plus 2) |  |  |
| 4 | **Less Privilege Tax Estimated Installments** |  |  |
|  | 4a | April 15, 1998 | xxxxxxxxxxxxxxxx |  |
|  | 4b | June 15, 1998 |  |  |
|  | 4c | September 15, 1998 |  |  |
|  | 4d | December 15, 1998 |  |  |
|  | 4e | Total: (Add 4a thru 4d) |  |  |
| 5 | **Less Retaliatory Tax Quarterly Estimates** |  |  |
|  | 5a | April 15, 1998 |  |  |
|  | 5b | June 15, 1998 |  |  |
|  | 5c | September 15, 1998 |  |  |
|  | 5d | December 15, 1998 |  |  |
|  | 5e | Total: (Add 5a thru 5d) |  |  |
| 6 | **Total Estimated Payments** (Lines 4e plus 5e) |  |  |
| 7 | **Less: Prior Year End Overpayment** |  |  |
|  | (as reported on prior year tax return) |  |  |
| 8 | **Total Credits**  (Line 6 plus line 7) |  |  |
| 9 | **Balance Due**  (Line 3 less Line 8) |  |  |
| \*10 | Failure to file tax return penalty ($200 per month or 5% of |  |  |
|  | tax whichever is greater) |  |  |
| \*11 | Failure to pay tax penalty (5% of tax due) |  |  |
| \*12 | Interest on the tax paid after due date per IRS rate, minimum |  |  |
|  | 12% |  |  |
| 13 | Total remittance with tax return (sum of Lines 9, 10, 11 and |  |  |
|  | 12 |  |  |
| \*\*14 | **Tax Overpayment** (if Line 8 is greater than Line 9) |  |  |
| \***Calculate per "215 ILCS 5/412" of the Illinois Compiled Statutes.** |
| **\*\*All overpayments must be applied to future privilege or retaliatory tax liabilities only.** |
|  |  |
|  | Name: | Title: | of the |
|  | (Signature of Corporate Officer) |  |
|  |  | (Company) |
|  | declares under penalties of perjury that the foregoing Statement (including the accompanying schedules) has been examined by him, and to the best of his knowledge and belief is true, correct and complete. |
|  | **Date:**  |  |  |
|  |
| 6 of 6 |

|  |  |
| --- | --- |
|  | **Illinois Department of Insurance** |
|  | **320 W. Washington Street** |
|  | **State of Illinois** | **Springfield, IL 62767-0001** |
| **1998 Privilege and Retaliatory Tax Statement for Life and Accident and Health Companies** |
| **Business during the Calendar Year 1998** | **Due: March 15, 1999** |
|  |
| Federal Employer Identification Number: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ NAIC: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_ |
|  |  |  |
| Name of Insurance Company |
| with principal office located at |  |  |
|  | Street and Number | City | State | Zip Code |
| incorporated under the laws of the State of |  | as required by and in |
| accordance with “215 ILCS 5/410” of the Illinois Compiled Statutes. |
| Mailing address, if other than principal office location shown above |  |  |
|  |  |  |
| Contact person: |  | Phone ( ) |  |  |
|  |
| **Instructions** |
|  | **Important Notice:** The FEIN must be on this statement to ensure proper posting to your company account. |
| 1 | The Privilege and Retaliatory Tax Statement must be filed and the taxes due must be paid on or before March 15, 1999. **The official filing date is the U.S. Postal date.** |
| 2 | Separate checks and statement is requested for each company of an insurance group. |
| 3 | The Department of Insurance cannot issue cash refunds of overpayments. Overpayments should be applied to all future privilege and retaliatory tax liabilities only. |
| 4 | No authority exists for granting any extension of time for filing or payment. |
| 5 | The payment received will be subject to audit and subsequent adjustments if necessary. |
| 6 | Any penalties to be levied will be assessed as provided by “215 ILCS 5/412,” Illinois Compiled Statutes. |
| 7 | File only one original notarized copy. The Illinois Department of Insurance will not accept computerized, fax or any facsimile tax statements. Companies must use the prescribed form furnished by the Department. Failure to do so will subject your company to penalties per "215 ILCS 5/412” of the Illinois Compiled Statutes. |
| 8 | Remittance should be made payable to the **Director of Insurance** and mailed with the completed tax statement to attention Tax and Fiscal Services Section, Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767-0001  |
| **Do not mail checks or forms with the Annual Statement.** |
| **Important Notice. Disclosure of this information is required under the Illinois Compiled Statutes’ Insurance Laws. Failure to provide this information will result in a fine. This form has been approved by the Forms Management Center.** |
| IL 446-0126-L | Printed on recycled paper |
| 1 of 6 |

|  |
| --- |
| NAIC Group Code \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ |
| NAIC Company Code \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ |
| **Direct Business in the State of Illinois During the Year 1998****Life Insurance** |
|  | 2 | 3 | 4 | 5 | 6 |
| Line of Business | Ordinary | Credit Life (Group and Individual) | Group | Industrial | Total |
| 1 | Life Insurance |  |  |  |  |  |
| 2 | Annuity considerations |  |  |  |  |  |
| 3 | Deposit-type funds |  |  |  |  |  |
| 4 | Totals (sum of Lines 1 to 3) |  |  |  |  |  |
| **Direct Dividends to Policyholders** |  |  |  |  |  |
|  | **Life Insurance:** |  |  |  |  |  |
| 5.1 | Paid in cash or left on deposit |  |  |  |  |  |
| 5.2 | Applied to pay renewal premiums |  |  |  |  |  |
| 5.3 | Applied to provide paid-up additions or shorten the endowment or premium- paying agent |  |  |  |  |  |
| 5.4 | Other |  |  |  |  |  |
| 5.5 | Totals (sum of 5.1 to 5.4) |  |  |  |  |  |
| . | **Annuities** |  |  |  |  |  |
| 6.1 | Paid in cash or left on deposit |  |  |  |  |  |
| 6.2 | Applies to provide paid-up annuities |  |  |  |  |  |
| 6.3 | Other |  |  |  |  |  |
| 6.4 | Totals (sum of 6.1 to 6.3) |  |  |  |  |  |
| 7 | Grand Totals (Lines 5.5 plus 6.4) |  |  |  |  |  |
| **Accident and Health Insurance** |
|  | 2 | 3 | 4 | 5 | 6 |
|  | Direct Premiums | Direct Premiums Earned | Dividends Paid or Credited on Direct Business | Direct Losses Paid | Direct Losses Incurred |
| 8 | Group Policies |  |  |  |  |  |
| 8.1 | Federal Employees Health Benefits Program Premium |  |  |  |  |  |
| 8.2 | Credit (Group and Individual) |  |  |  |  |  |
| 8.3 | Collectively Renewable Policies |  |  |  |  |  |
|  | **Other Individual Policies** |  |  |  |  |  |
| 9.1 | Non-cancellable |  |  |  |  |  |
| 9.2 | Guaranteed Renewable |  |  |  |  |  |
| 9.3 | Non-renewable for stated reasons only |  |  |  |  |  |
| 9.4 | Other accidents only |  |  |  |  |  |
| 9.5 | All other |  |  |  |  |  |
| 9.6 | Totals (sum of 9.1 to 9.5) |  |  |  |  |  |
| 10 | Total (Lines 8 + 8.1 + 8.2 + 8.3 + 9.6) |  |  |  |  |  |
| **Amounts Must Agree to Direct Business Page of Company’s Annual Statement.** |
| 2 of 6 |

|  |  |
| --- | --- |
|  | **Life and Accident and Health Insurance Companies** |
| **Privilege Tax Calculation** | **1****Premium** | **2****Premium Rate** | **3****Premium Tax** |
| 1 | Life Insurance Premiums (Page 21 Column 6. Line 1 per Annual Statement  |  |  |  |
| 2 | DEDUCTIONS |  |  |  |
|  | a | Dividends Paid in Cash |  |  |  |
|  | b | Dividends Applied in Reduction of Premiums |  |  |  |
|  | c | Return Premiums |  |  |  |
|  | d | Total Deductions |  |  |  |
| 3 | NET TAXABLE DIRECT LIFE PREMIUMS (Column 1. Line 1 minus 2d) |  |  |  |
| 4 | Net Direct Life Premium Tax (Line 3. Column 1 x Column 2) |  | .005 |  |
| 5 | Accident and Health Premiums (Page 21. Column 2. Line 25 minus Line 23.1 per Annual Statement) (July 1 thru December 31, 1998) |  |  |  |
| 6 | DEDUCTIONS |  |  |  |
|  | Dividends Paid in Cash or Credited to Policyholders on premiums reported on Line 5 (July thru Dec 31, 1998) |  |  |  |
| 7 | NET TAXABLE ACCIDENT AND HEALTH PREMIUMS (Column 1. Line 5 minus Line 6) (July 1 thru Dec 31, 1998) |  |  |  |
| 8 | Net Accident & Health Premium Tax (Line 7. Column 1 x Column 2) |  | .004 |  |
| 9 | **Net Premium Tax Before Credits (Column 3. Line 4 plus Column 3. Line 8)** |  |  |  |
|  | **Less Credits to the Privilege Tax** |  |  |  |
|  | CORPORATE & REPLACEMENT INCOME TAX INTERGRADATION EXCESS |  |  |  |
|  | Complete Lines 10 thru 11 if Corporate and Replacement Income Taxes are not paid on a Unitary Method. If paid on a Unitary Method, go to U-1 Schedule and complete as directed  |  |  |  |
| 10 | ILLINOIS CORPORATE INCOME TAX PAYMENTS |  |  |  |
|  | 10a | 1997 Final Payment |  |  |  |
|  | 10b | 1998 Total Quarterly Payments |  |  |  |
|  | 10c | Other Payments paid during Calendar Year 1998 |  |  |  |
|  | 10d | Less State Income Tax Cash Refunds Received |  |  |  |
|  | 10e | TOTAL |  |  |  |
| 11 | ILLINOIS PERSONAL PROPERTY REPLACEMENT CORPORATE INCOME TAX PAYMENTS |  |  |  |
|  | 11a | 1997 Final Payment |  |  |  |
|  | 11b | 1998 Total Quarterly Payments |  |  |  |
|  | 11c | Other Payments paid during Calendar Year 1998 |  |  |  |
|  | 11d | Less Replacement State Income Tax Cash Refunds Received |  |  |  |
|  | 11e | TOTAL |  |  |  |
| 12 | TOTAL NET INCOME TAXES (10e plus 11e) |  |  |  |
| 13 | Unitary Member Income Tax Offset (Schedule U-1) |  |  |  |
| 14 | Total Life Insurance Premium & Accident and Health Premium (Column 1. Line 3 plus Column 1. Line 7) |  |  |  |
| 15 | Intergradation Offset is excess of 1.5% Net Taxable Premium (Line 14 x 1.5%) |  |  |  |
| 16 | Intergradation Offset Amount (Line 12 or 13 minus Line 15) If negative enter zero |  |  |  |
| 17 | NET PREMIUM TAX (Line 9 minus Line 16) (cannot be less than -0-) |  |  |  |
| 3 of 6 |

|  |
| --- |
| **Computation of Retaliatory Taxes** |
| Under “215 ILCS 5/444 and 5/444.1” of the Illinois Compiled Statutes, when the laws of any other state require of companies domiciled in Illinois the payment of penalties, fees, charges or taxes greater than those required in the aggregate for like purposes under the laws of Illinois by companies domiciled in such states, the Director of Insurance is required to impose comparable requirements on a retaliatory basis. All insurance related taxes and fees, including premium taxes, based on the State of Incorporation requirements, should be calculated below with the total carried forward to Page 6, Line 2 under Column 2.  |
| **Retaliatory Tax Calculation** | **Column 1** | **Column 2** |
| **State of Illinois Basis** | **State of Incorporation Basis** |
| 1 | Annual Statement Filing Fee | $100.00 |  |
| 2 | Certificate of Authority Fee | $100.00 |  |
| 3 | Fire Marshal Tax |  |  |
| 4 | Fire Department Tax (proof of payment must be attached) |  |  |
| 5 | Financial Regulation Fee |  |  |
| 6 | Policy Form Filing Fee |  |  |
| \*7a | Illinois Corporate & Replacement Income Taxes Paid |  | xxxxxxxxxxxxxx |
| 7b | Illinois Life & Health Guaranty Fund Credit (per Association's  |  | xxxxxxxxxxxxxx |
|  | official notice) |
| 7c | Other State of Illinois Taxes and Fees per Article XXV |  | xxxxxxxxxxxxxx |
| 7d | Other State of Incorporation Taxes and Fees | xxxxxxxxxxxxxx |  |
| 7e | State of Incorporation income tax paid without reduction, if any  | xxxxxxxxxxxxxx |  |
|  | is otherwise allowed, for a similar association offset as the Illinois Life and Health Guaranty Association per Section 2515.50(c)(5) |
| 8 | Privilege Premium Tax Franchise Tax, etc |  |  |
| 9 | Total Illinois Basis |  | xxxxxxxxxxxxxx |
| 10 | Total State of Incorporation Basis | xxxxxxxxxxxxxx |  |
| 11 | Total Retaliatory Tax Due (Line 10 minus Line 9: balance | xxxxxxxxxxxxxx |  |
|  | cannot be less than -0-). |
| **\*If Illinois Corporate and Replacement income taxes are paid on a unitary method, please complete Schedule U-1****in detail. Proof of Payment (cancelled checks and IL 1120) must be attached to verify basis.** |
| 4 of 6 |

|  |
| --- |
| **Income Tax Offset Based on Unitary Method of Corporate and Replacement Tax** |
| **Allocated by each Company’s Illinois Premium Written (including annuities)****to the Unitary Group’s Total Illinois Premium Written (Schedule U-1)** |
|  | **Identity** | **Payment** |  | **Refund** | **Results** |
|  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|  | **Company Name of Each Unitary Member** | **Company FEIN** | **Illinois Direct Premium** | **Percentage Allocation** | **Tax Offset Allocated by Percentage** | **Refund Offset Allocation by %** | **Allowed** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
| 15 | Column Totals |  |  |  |  |  |  |
| Taxes Paid By (Name of Company and the FEIN of Taxpayer)  |  |  |
|  |  |  |
| Total Taxes Paid  |  |  |
| Total Refund Issued  |  |  |
| Net Available for Offset  |  |  |
| (This amount will be verified per the Department of Revenue records.) |
|  |
| **Procedure to Determine the Income Tax Offset on the Unitary Method** |
| We will use Schedule U-1 to determine the income tax offset for companies using the Unitary Method. The allocation of the total income tax paid will be based on the Illinois premium written (including annuities) by each individual company as a percent of the Unitary group total. This allocation is multiplied to the unitary calendar year amount paid and the result is the available income tax offset for that individual company. |
| If the unitary group received a refund during the calendar year the refund must also be allocated among the individual companies. If a member of the unitary group received a refund during the calendar year the refund must be allocated among all members of the unitary group. Only the net amount is allowed. |
| Each unitary group must complete Schedule U-1 to be allowed the offset. Any unitary group that does **not** complete Schedule U-1 will not be allowed to use the Illinois Corporate and Replacement income taxes in the calculation of the privilege and retaliatory taxes. |
| 5 of 6 |

|  |  |  |
| --- | --- | --- |
| **Payment Summary** | **Column 1** | **Column 2** |
| 1 | Amount due as Privilege Tax (Line 17. Page 3) |  |  |
| 2 | Amount due as Retaliatory Tax (Line 11. Page 4) |  |  |
| 3 | Total Privilege and Retaliatory Tax (Line 1 plus 2) |  |  |
| 4 | **Less Privilege Tax Estimated Installments** |  |  |
|  | 4a | April 15, 1998 | xxxxxxxxxxxxxxxx |  |
|  | 4b | June 15, 1998 |  |  |
|  | 4c | September 15, 1998 |  |  |
|  | 4d | December 15, 1998 |  |  |
|  | 4e | Total: (Add 4a thru 4d) |  |  |
| 5 | **Less Retaliatory Tax Quarterly Estimates** |  |  |
|  | 5a | April 15, 1998 |  |  |
|  | 5b | June 15, 1998 |  |  |
|  | 5c | September 15, 1998 |  |  |
|  | 5d | December 15, 1998 |  |  |
|  | 5e | Total: (Add 5a thru 5d) |  |  |
| 6 | **Total Estimated Payments** (Lines 4e plus 5e) |  |  |
| 7 | **Less: Prior Year End Overpayment** |  |  |
|  | (as reported on prior year tax return) |  |  |
| 8 | **Total Credits**  (Line 6 plus line 7) |  |  |
| 9 | **Balance Due**  (Line 3 less Line 8) |  |  |
| \*10 | Failure to file tax return penalty ($200 per month or 5% of |  |  |
|  | tax whichever is greater) |  |  |
| \*11 | Failure to pay tax penalty (5% of tax due) |  |  |
| \*12 | Interest on the tax paid after due date per IRS rate, minimum |  |  |
|  | 12% |  |  |
| 13 | Total remittance with tax return (sum of Lines 9, 10, 11 and |  |  |
|  | 12 |  |  |
| \*\*14 | **Tax Overpayment** (if Line 8 is greater than Line 9) |  |  |
| \***Calculate per "215 ILCS 5/412" of the Illinois Compiled Statutes.** |
| **\*\*All overpayments must be applied to future privilege or retaliatory tax liabilities only.** |
|  |  |
|  | Name: | Title: | of the |
|  | (Signature of Corporate Officer) |  |
|  |  | (Company) |
|  | declares under penalties of perjury that the foregoing Statement (including the accompanying schedules) has been examined by him, and to the best of his knowledge and belief is true, correct and complete. |
|  | **Date:**  |  |  |
|  |
| 6 of 6 |

|  |  |
| --- | --- |
|  | **Illinois Department of Insurance** |
|  | **320 W. Washington Street** |
|  | **State of Illinois** | **Springfield, IL 62767-0001** |
| **1998 Privilege and Retaliatory Tax Statement for Health Maintenance Organizations, Limited****Health Service Organizations, Voluntary Health Service Plans and Dental Service Plans** |
| **Business during the Calendar Year 1998** | **Due: March 15, 1999** |
|  |
| Federal Employer Identification Number: \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ NAIC: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_ |
|  |  |  |
| Name of Insurance Company |
| with principal office located at |  |  |
|  | Street and Number | City | State | Zip Code |
| incorporated under the laws of the State of |  | as required by and in |
| accordance with “215 ILCS 5/410” of the Illinois Compiled Statutes. |
| Mailing address, if other than principal office location shown above |  |  |
|  |  |  |
| Contact person: |  | Phone ( ) |  |  |
|  |
| **Instructions** |
|  | **Important Notice:** The FEIN must be on this statement to ensure proper posting to your company account. |
| 1 | The Privilege and Retaliatory Tax Statement must be filed and the taxes due must be paid on or before March 15, 1999. **The official filing date is the U.S. Postal date.** |
| 2 | Separate checks and statement is requested for each company of an insurance group. |
| 3 | The Department of Insurance cannot issue cash refunds of overpayments. Overpayments should be applied to all future privilege and retaliatory tax liabilities only. |
| 4 | No authority exists for granting any extension of time for filing or payment. |
| 5 | The payment received will be subject to audit and subsequent adjustments if necessary. |
| 6 | Any penalties to be levied will be assessed as provided by “215 ILCS 5/412,” Illinois Compiled Statutes. |
| 7 | File only one original notarized copy. The Illinois Department of Insurance will not accept computerized, fax or any facsimile tax statements. Companies must use the prescribed form furnished by the Department. Failure to do so will subject your company to penalties per "215 ILCS 5/412” of the Illinois Compiled Statutes. |
| 8 | Remittance should be made payable to the **Director of Insurance** and mailed with the completed tax statement to attention Tax and Fiscal Services Section, Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767-0001  |
| **Do not mail checks or forms with the Annual Statement.** |
| **Important Notice. Disclosure of this information is required under the Illinois Compiled Statutes’ Insurance Laws. Failure to provide this information will result in a fine. This form has been approved by the Forms Management Center.** |
| IL 446-0126-H | Printed on recycled paper |
| 1 of 6 |

|  |
| --- |
| **Only Complete the Part Applicable to Your License.** |
| **Type of Organization or Plan** | **Premium** |
| **Health Maintenance Organization** |  |
| Premium taxable effective January 1, 1999 |  |
| Net taxable premium per Schedule T of the Annual Statement, Page 60, Line 14, Column 4 |  |
| **Limited Health Service Organizations** |  |
| Net taxable premium per Schedule T of the Annual Statement, Page 56, Line 14, Column 4 |  |
| **Voluntary Health Service Plans** |  |
| Net taxable premium per schedule T of the Annual Statement, Page 56, Line 14, Column 4 |  |
| **Dental Service Plans** |  |
| Net taxable premium per the Annual Statement, Page 7, Line 4, Column 1 |  |
|  |
| 2 of 6 |

|  |  |
| --- | --- |
|  |  |
| **Privilege Tax Calculation** | **1****Premium** | **2****Premium Rate** | **3****Premium Tax** |
| 1. | PREMIUMS |  |  |  |
| 2. | NET PREMIUM TAX (Column 1. Line 1 x Column 2) |  | .004 |  |
|  | **Less Credits to the Privilege Tax** |  |  |  |
|  | CORPORATE & REPLACEMENT INCOME TAX INTERGRADATION EXCESS |  |  |  |
|  | Complete Lines 3 thru 4 if Corporate and Replacement Income Taxes are not paid on a Unitary Method. If paid on a Unitary Method, go to U-1 Schedule and complete as directed  |  |  |  |
| 3. | ILLINOIS CORPORATE INCOME TAX PAYMENTS |  |  |  |
|  | 3a | 1997 Final Payment |  |  |  |
|  | 3b | 1998 Total Quarterly Payments |  |  |  |
|  | 3c | Other Payments paid during Calendar Year 1998 |  |  |  |
|  | 3d | Less State Income Tax Cash Refunds Received |  |  |  |
|  | 3e | TOTAL |  |  |  |
| 4. | ILLINOIS PERSONAL PROPERTY REPLACEMENT CORPORATE INCOME TAX PAYMENTS |  |  |  |
|  | 4a | 1997 Final Payment |  |  |  |
|  | 4b | 1998 Total Quarterly Payments |  |  |  |
|  | 4c | Other Payments paid during Calendar Year 1998 |  |  |  |
|  | 4d | Less Replacement State Income Tax Cash Refunds Received |  |  |  |
|  | 4e | TOTAL |  |  |  |
| 5. | TOTAL NET INCOME TAXES (12e plus 13e) |  |  |  |
| 6. | Unitary Member Income Tax Offset (Schedule U-1) |  |  |  |
| 7. | Intergradation Offset is excess of 1.5% Net Taxable Premium (Line 1 Column 1 x 1.5%) |  |  |  |
| 8. | Intergradation Offset Amount (Line 5 or 6 minus Line 7 if negative enter -0-) |  |  |  |
| 9. | NET PREMIUM TAX (Line 2 Column 3 minus Line 8) |  |  |  |

|  |
| --- |
| 3 of 6 |

|  |
| --- |
| **Computation of Retaliatory Taxes** |
| Under “215 ILCS 5/444 and 5/444.1” of the Illinois Compiled Statutes, when the laws of any other state require of companies domiciled in Illinois the payment of penalties, fees, charges or taxes greater than those required in the aggregate for like purposes under the laws of Illinois by companies domiciled in such states, the Director of Insurance is required to impose comparable requirements on a retaliatory basis. All insurance related taxes and fees, including premium taxes, based on the State of Incorporation requirements, should be calculated below with the total carried forward to Page 6, Line 2 under Column 2.  |
| **Retaliatory Tax Calculation** | **Column 1** | **Column 2** |
| **State of Illinois Basis** | **State of Incorporation Basis** |
| 1 | Annual Statement Filing Fee | $100.00 |  |
| 2 | Certificate of Authority Fee | $100.00 |  |
| 3 | Fire Marshal Tax |  |  |
| 4 | Fire Department Tax (proof of payment must be attached) |  |  |
| 5 | Financial Regulation Fee |  |  |
| 6 | Policy Form Filing Fee |  |  |
| \*7a | Illinois Corporate & Replacement Income Taxes Paid |  | xxxxxxxxxxxxxx |
| 7b | Illinois Life & Health Guaranty Fund Credit (per Association's  |  | xxxxxxxxxxxxxx |
|  | official notice) |
| 7c | Other State of Illinois Taxes and Fees per Article XXV |  | xxxxxxxxxxxxxx |
| 7d | Other State of Incorporation Taxes and Fees | xxxxxxxxxxxxxx |  |
| 7e | State of Incorporation income tax paid without reduction, if any  | xxxxxxxxxxxxxx |  |
|  | is otherwise allowed, for a similar association offset as the Illinois Life and Health Guaranty Association per Section 2515.50(c)(5) |
| 8 | Privilege Premium Tax Franchise Tax, etc |  |  |
| 9 | Total Illinois Basis |  | xxxxxxxxxxxxxx |
| 10 | Total State of Incorporation Basis | xxxxxxxxxxxxxx |  |
| 11 | Total Retaliatory Tax Due (Line 10 minus Line 9: balance | xxxxxxxxxxxxxx |  |
|  | cannot be less than -0-). |
| **\*If Illinois Corporate and Replacement income taxes are paid on a unitary method, please complete Schedule U-1****in detail. Proof of Payment (cancelled checks and IL 1120) must be attached to verify basis.** |
| 4 of 6 |

|  |
| --- |
| **Income Tax Offset Based on Unitary Method of Corporate and Replacement Tax** |
| **Allocated by each Company’s Illinois Premium Written (including annuities)****to the Unitary Group’s Total Illinois Premium Written (Schedule U-1)** |
|  | **Identity** | **Payment** |  | **Refund** | **Results** |
|  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
|  | **Company Name of Each Unitary Member** | **Company FEIN** | **Illinois Direct Premium** | **Percentage Allocation** | **Tax Offset Allocated by Percentage** | **Refund Offset Allocation by %** | **Allowed** |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
| 15 | Column Totals |  |  |  |  |  |  |
| Taxes Paid By (Name of Company and the FEIN of Taxpayer)  |  |  |
|  |  |  |
| Total Taxes Paid  |  |  |
| Total Refund Issued  |  |  |
| Net Available for Offset  |  |  |
| (This amount will be verified per the Department of Revenue records.) |
|  |
| **Procedure to Determine the Income Tax Offset on the Unitary Method** |
| We will use Schedule U-1 to determine the income tax offset for companies using the Unitary Method. The allocation of the total income tax paid will be based on the Illinois premium written (including annuities) by each individual company as a percent of the Unitary group total. This allocation is multiplied to the unitary calendar year amount paid and the result is the available income tax offset for that individual company. |
| If the unitary group received a refund during the calendar year the refund must also be allocated among the individual companies. If a member of the unitary group received a refund during the calendar year the refund must be allocated among all members of the unitary group. Only the net amount is allowed. |
| Each unitary group must complete Schedule U-1 to be allowed the offset. Any unitary group that does **not** complete Schedule U-1 will not be allowed to use the Illinois Corporate and Replacement income taxes in the calculation of the privilege and retaliatory taxes. |
| 5 of 6 |

|  |  |  |
| --- | --- | --- |
| **Payment Summary** | **Column 1** | **Column 2** |
| 1 | Amount due as Privilege Tax (Line 19. Page 3) |  |  |
| 2 | Amount due as Retaliatory Tax (Line 11. Page 4) |  |  |
| 3 | Total Privilege and Retaliatory Tax (Line 1 plus 2) |  |  |
| 4 | **Less Privilege Tax Estimated Installments** |  |  |
|  | 4a | April 15, 1998 | xxxxxxxxxxxxxxxx |  |
|  | 4b | June 15, 1998 |  |  |
|  | 4c | September 15, 1998 |  |  |
|  | 4d | December 15, 1998 |  |  |
|  | 4e | Total: (Add 4a thru 4d) |  |  |
| 5 | **Less Retaliatory Tax Quarterly Estimates** |  |  |
|  | 5a | April 15, 1998 |  |  |
|  | 5b | June 15, 1998 |  |  |
|  | 5c | September 15, 1998 |  |  |
|  | 5d | December 15, 1998 |  |  |
|  | 5e | Total: (Add 5a thru 5d) |  |  |
| 6 | **Total Estimated Payments** (Lines 4e plus 5e) |  |  |
| 7 | **Less: Prior Year End Overpayment** |  |  |
|  | (as reported on prior year tax return) |  |  |
| 8 | **Total Credits**  (Line 6 plus line 7) |  |  |
| 9 | **Balance Due**  (Line 3 less Line 8) |  |  |
| \*10 | Failure to file tax return penalty ($200 per month or 5% of |  |  |
|  | tax whichever is greater) |  |  |
| \*11 | Failure to pay tax penalty (5% of tax due) |  |  |
| \*12 | Interest on the tax paid after due date per IRS rate, minimum |  |  |
|  | 12% |  |  |
| 13 | Total remittance with tax return (sum of Lines 9, 10, 11 and |  |  |
|  | 12 |  |  |
| \*\*14 | **Tax Overpayment** (if Line 8 is greater than Line 9) |  |  |
| \***Calculate per "215 ILCS 5/412" of the Illinois Compiled Statutes.** |
| **\*\*All overpayments must be applied to future privilege or retaliatory tax liabilities only.** |
|  |  |
|  | Name: | Title: | of the |
|  | (Signature of Corporate Officer) |  |
|  |  | (Company) |
|  | declares under penalties of perjury that the foregoing Statement (including the accompanying schedules) has been examined by him, and to the best of his knowledge and belief is true, correct and complete. |
|  | **Date:**  |  |  |
|  |
| 6 of 6 |

**Quarterly Tax Statement**

|  |  |
| --- | --- |
|  | **Illinois Department of Insurance** |
|  | **320 W. Washington Street** |
|  | **State of Illinois** | **Springfield, IL 62767-0001** |
|  | **Privilege and Retaliatory Tax Installment** |
|  | **All companies whose annual tax for the preceding calendar year was less than $5,000 need not file this statement** |
| Federal Employer Identification Number \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_ | 1999 Calendar Year |
|  |  | Indicate which filing: |
| By the |  | Insurance Company | [ ]  April 15, 1999 |
|  |  | [ ]  June 15, 1999 |
| of |  |  | [ ]  September 15, 1999 |
| Street and Number | City | State | Zip Code | [ ]  December 15, 1999 |
| **Privilege Tax** |
| PART A - BASED ON PRIOR YEAR TOTAL TAX |  |
| 1 | 1998 Privilege Tax from Page 6, Line 1 of Privilege and Retaliatory Tax Statement | $ |  |  |
| 2 | Installment amount due is ¼ of Line 1 | $ |  |  |
| PART B - BASED ON CURRENT CALENDAR YEAR  |  |  |  |
| 3 | 1999 Estimated Privilege Tax on taxable premiums | $ |  |  |
|  | 3a | Less Estimated Fire Department Taxes to be paid in 1999, if applicable | $ |  |  |
|  | 3b | Less Estimated Intergradation 1999 excess Income Tax Offset, if applicable  | $ |  |  |
| 4 | Net Privilege Tax for 1999 (Line 3 minus sum of 3a and 3b) | $ |  |  |
| 5 | 80% of Line 4 to be paid in 1999 | $ |  |  |
| 6 | Installment amount due is ¼ of Line 5 | $ |  |  |
|  |
| **Retaliatory Tax** |
| PART A - BASED ON PRIOR YEAR TOTAL TAX |  |
| 7 | 1998 Retaliatory Tax from Page 6, Line 2 of Privilege and Retaliatory Tax Statement | $ |  |  |
| 8 | Installment amount due is ¼ of Line 7 | $ |  |  |
| PART B - BASED ON CURRENT CALENDAR YEAR  |  |  |  |
| 9 | 80% of 1999 Estimated Retaliatory Tax | $ |  |  |
| 10 | Installment amount due is ¼ of Line 9 | $ |  |  |
|  |
| **Payment** |
| 11 | Amount due as a Privilege Tax from Line 2 or Line 6 | $ |  |  |
| 12 | Amount due as a Retaliatory Tax either Line 8 or Line 10 | $ |  |  |
| 13 | Amount due this installment Line 11 plus Line 12 | $ |  |  |
| 14 | Less Previous Privilege or Retaliatory Tax overpayment(Amount may not be more than Line 13) | $ |  |  |
| 15 | Amount of tax payment due this installment Line 13 minus Line 14 | $ |  |  |
| I certify that this a true, correct and complete Declaration of taxes due. (print name) |  |  |
|  |  |  |
| Signature of Company Officer | Date | Phone |
| Please complete and return one copy of this tax statement each quarter. Remittance should be payable to Director of Insurance and mailed to attention: Tax and Fiscal Services Section, Illinois Department of Insurance, 320 West Washington Street, Springfield, Illinois 62767-0001. |
| Important Notice Disclosure of this information is required under the Illinois Compiled Statutes insurance laws. Failure to provide this information could result in affine. This form has been approved by the Forms Management Center. |
| PRT1 |  | Printed on recycled paper |