

STATE OF ALABAMA

PD-G

DEPARTMENT OF INSURANCE

QUARTERLY PREMIUM TAX STATEMENT – HEALTH MAINTENANCE ORGANIZATION

Quarterly Period Ending March 31, _____

(Due no later than May 15, _____)

INSTRUCTIONS

PENALTIES – Any Company failing to file its Premium Tax Return (even if no tax is due) or failing to pay such estimated taxes on a timely basis shall be subject to a penalty of \$1,000 to \$10,000, to be assessed by the Commissioner.

RETURNS POST MARKED ON THE DUE DATE WILL BE ACCEPTED.

Please use the following checklist to assure that all the necessary items are included with your Premium Tax Filing.

- () Each quarter’s payment may be paid on Estimated or Actual premiums.
() Make checks payable to the: Alabama Department of Insurance.
() WE DO NOT HAVE AN EFT ACCOUNT AT THIS TIME. Premium Tax Return and Check must be mailed to the address below.

POSTAL SERVICE

COURIER OR EXPRESS SERVICE

Alabama Department of Insurance
c/o Compass Bank
P.O. Box 830691
Birmingham, AL 35283-0691

Alabama Department of Insurance
c/o Compass Bank
701 South 32nd Street
Birmingham, AL 35233

NAIC#: [Green Box] _____
(Name of Company)

Preparer’s Signature _____ Name and Title (Print) _____

Telephone Number & E-Mail Address of Preparer _____

PLEASE COMPLETE
1. PREMIUM TAX PAID: (reverse side, line 9) PD: \$ [Box]
2. Check No.: -----

STATE OF _____ COUNTY OF _____

Personally appeared before the undersigned attesting officer(Name)

Who says he/she is (Title) _____ of the above company and the above statement is true and correct to the best of his/her knowledge.

SWORN TO AND SUBSCRIBED before me this ____ day of _____, 20 ____.

_____ NOTARY PUBLIC

HEALTH MAINTENANCE ORGANIZATION
Quarterly Period Ending March 31, _____
(Due no later than May 15, _____)

PD-G

NAIC#

NAME OF COMPANY _____

TAXABLE PREMIUMS

ACTUAL:

THIS QUARTER TAX RATE TAX

3. Health:

- a) Groups less than 50 participants
- b) Other Health, excluding insurance supplementary to Medicaid or Medicare & employer sponsored, governmental sponsored group insurance

\$ _____ X .5% = \$ _____

\$ _____ X 1.6% = \$ _____

4. GROSS TAX DUE – ACTUAL BASIS

\$ _____

ESTIMATED:

PREVIOUS YEAR TAX RATE TAX

5. Health:

- a) Groups less than 50 participants
- b) Other Health, excluding insurance supplementary to Medicaid or Medicare & employer sponsored, governmental sponsored group insurance

\$ _____ X 25% X .5% = \$ _____

\$ _____ X 25% X 1.6% = \$ _____

6. GROSS TAX DUE - ESTIMATED BASIS

\$ _____

7. 25% of deductible expenses paid or estimated to be paid

\$ _____

8. LESS: Prior Year Overpayment

\$ _____

9. NET PREMIUM TAX DUE

(line 4 or line 6 minus lines 7 and 8)

\$ _____

STATE OF ALABAMA
DEPARTMENT OF INSURANCE

PD-G

QUARTERLY PREMIUM TAX STATEMENT – HEALTH MAINTENANCE ORGANIZATION

Quarterly Period Ending June 30, _____

(Due no later than August 15, _____)

INSTRUCTIONS

PENALTIES – Any Company failing to file its Premium Tax Return (even if no tax is due) or failing to pay such estimated taxes on a timely basis shall be subject to a penalty of \$1,000 to \$10,000, to be assessed by the Commissioner.

RETURNS POST MARKED BY THE DUE DATE WILL BE ACCEPTED.

Please use the following checklist to assure that all the necessary items are included with your Premium Tax Filing.

- () Each quarter's payment may be paid on Estimated or Actual premiums.
- () Make checks payable to the: Alabama Department of Insurance.
- () **WE DO NOT HAVE AN EFT ACCOUNT AT THIS TIME.** Premium Tax Return and Check must be mailed to the address below:

POSTAL SERVICE

Alabama Department of Insurance
c/o Compass Bank
P.O. Box 830691
Birmingham, AL 35283-0691

COURIER OR EXPRESS SERVICE

Alabama Department of Insurance
c/o Compass Bank
701 South 32nd Street
Birmingham, AL 35233

NAIC#:

(Name of Company)

Preparer's Signature

Name and Title (Print)

Telephone Number & E-Mail Address of Preparer

PLEASE COMPLETE

1. **PREMIUM TAX PAID:** (reverse side, line 9)

PD: \$

2. **Check No.:** -----

STATE OF _____ COUNTY OF _____

Personally appeared before the undersigned attesting officer(Name) _____

Who says he/she is (Title) _____ of the above company and the above statement is true and correct to the best of his/her knowledge.

SWORN TO AND SUBSCRIBED before me this ____ day of _____, 20 ____.

NOTARY PUBLIC

HEALTH MAINTENANCE ORGANIZATION

PD-G

Quarterly Period Ending June 30, _____

(Due no later than August 15, _____)

NAIC# _____

NAME OF COMPANY _____

TAXABLE PREMIUMS

<u>ACTUAL:</u>	<u>THIS QUARTER</u>	<u>TAX RATE</u>	<u>TAX</u>
3. Health:			
a) Groups less than 50 participants	\$ _____	X 180% X .5% =	\$ _____
b) Other Health, excluding insurance supplementary to Medicaid or Medicare & employer sponsored, governmental sponsored group insurance	\$ _____	X 180% X 1.6% =	\$ _____
4. GROSS PREMIUM TAX DUE - ACTUAL BASIS			\$ _____

<u>ESTIMATED:</u>	<u>PREVIOUS YEAR</u>	<u>TAX RATE</u>	<u>TAX</u>
5. Health:			
a) Groups less than 50 participants	\$ _____	X 45% X .5% =	\$ _____
b) Other Health, excluding insurance supplementary to Medicaid or Medicare & employer sponsored, governmental sponsored group insurance	\$ _____	X 45% X 1.6% =	\$ _____
6. GROSS TAX DUE - ESTIMATED BASIS			\$ _____
7. 25% of deductible expenses paid or estimated to be paid			\$ _____
8. LESS: Prior Year Overpayment			\$ _____
9. NET PREMIUM TAX DUE (line 4 or 6 minus lines 7 and 8)			\$ _____

STATE OF ALABAMA

PD-G

DEPARTMENT OF INSURANCE

QUARTERLY PREMIUM TAX STATEMENT – HEALTH MAINTENANCE ORGANIZATION

Quarterly Period Ending September 30, _____

(Due no later than November 15, _____)

INSTRUCTIONS

PENALTIES – Any Company failing to file its Premium Tax Return (even if no tax is due) or failing to pay such estimated taxes on a timely basis shall be subject to a penalty of \$1,000 to \$10,000, to be assessed by the Commissioner.

RETURNS POST MARKED ON THE DUE DATE WILL BE ACCEPTED.

Please use the following checklist to assure that all the necessary items are included with your Premium Tax Filing.

- () Each quarter’s payment may be paid on Estimated or Actual premiums.
() Make checks payable to the: Alabama Department of Insurance.
() WE DO NOT HAVE AN EFT ACCOUNT AT THIS TIME. Premium Tax Return and Check must be mailed to the address below:

POSTAL SERVICE

COURIER OR EXPRESS SERVICE

Alabama Department of Insurance
c/o Compass Bank
P.O. Box 830691
Birmingham, AL 35283-0691

Alabama Department of Insurance
c/o Compass Bank
701 South 32nd Street
Birmingham, AL 35233

NAIC#: [Green box]

(Name of Company)

Preparer’s Signature

Name and Title (Print)

Telephone Number & E-Mail Address of Preparer

PLEASE COMPLETE

1. PREMIUM TAX PAID: (reverse side, line 9)

PD: \$ [Green box]

2. Check No.: -----

STATE OF _____ COUNTY OF _____

Personally appeared before the undersigned attesting officer(Name)

Who says he/she is (Title) _____ of the above company and the above statement is true and correct to the best of his/her knowledge.

SWORN TO AND SUBSCRIBED before me this ____ day of _____, 20 ____.

NOTARY PUBLIC

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
ANNUAL PREMIUM TAX STATEMENT - FOREIGN HMO
for the Period Ending December 31, _____

PD-G

INSTRUCTIONS

PENALTIES – Any Company failing to file its **Premium Tax Return** (even when no tax is due) or failing to pay such taxes on a timely basis shall be subject to a penalty of \$1,000 to \$10,000, to be assessed by the Commissioner. **ANY COMPANY, OTHER THAN A FRATERNAL, FAILING TO FILE THE ANNUAL STATEMENT ON A TIMELY BASIS SHALL BE SUBJECT TO A PENALTY OF \$250 AND MAY HAVE ITS CERTIFICATE OF AUTHORITY SUSPENDED OR REVOKED.** Fraternal shall be subject to a penalty of \$100 per day for each day the Annual Statement is late.

RETURNS POST MARKED ON THE DUE DATE WILL BE ACCEPTED.

Please use the following checklist to assure that all the necessary items are included with your Premium Tax Filing.

- () Include two (2) forms of supporting documentation for each credit taken on the reverse side.
- () Make checks payable to the: Alabama Department of Insurance. **WE DO NOT HAVE AN EFT ACCOUNT AT THIS TIME.**
- () Please submit **TWO CHECKS**: one in payment of Fees, and one in payment of Premium Taxes due the State of Alabama.
- () Please mail the following documents to the address below: Annual Premium Tax Return and checks, the Annual Financial Statement, and the Application for License Renewal. **These items should be mailed together.**

POSTAL SERVICE
Alabama Department of Insurance
c/o Compass Bank
P. O. Box 830691
Birmingham, AL 35283-0691

COURIER OR EXPRESS SERVICE
Alabama Department of Insurance
c/o Compass Bank
701 South 32nd Street
Birmingham, AL 35233

NAIC# _____

COMPANY NAME _____

COMPANY MAILING ADDRESS _____

CONTACT PERSON _____ TELEPHONE _____

E-MAIL ADDRESS _____

LICENSE RENEWAL FEES				
FEES: Renewal of Certificate of Authority	<table border="1" style="width: 100%;"><tr><td style="width: 10%;">PI</td><td style="width: 10%;">\$</td><td style="width: 80%; text-align: right;">205.00</td></tr></table>	PI	\$	205.00
PI	\$	205.00		
Annual Statement Filing Fee: Check No. _____	<table border="1" style="width: 100%;"><tr><td style="width: 10%;">PJ</td><td style="width: 10%;">\$</td><td style="width: 80%; text-align: right;">20.00</td></tr></table>	PJ	\$	20.00
PJ	\$	20.00		

STATE OF _____, COUNTY OF _____

_____, President and _____ Secretary

of the _____ Insurance Company being duly sworn, each for himself, deposes and says, that they are the above described officers of said Company and that the foregoing statement of business transacted during such year and showing the true status of same on December 31, of such year, is full and correct according to the best of their information, knowledge and belief, respectively.

Subscribed & sworn before me this _____

_____ President

Day of _____, 20 _____.

_____ Secretary

My commission expires _____

_____ Notary Public

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
ANNUAL PREMIUM TAX STATEMENT - FOREIGN HMO
for the Year Ending December 31, _____

NAME OF COMPANY _____

PREMIUMS less DIVIDENDS & RETURNS

1.	HEALTH:				
	a) Groups with less than 50 participants	GL50--	\$ _____	X	<u>.5%</u> = \$ _____
	b) Other Health	OH--	\$ _____		
	LESS: Medicare & Medicaid Supplement policies	MMP--	\$ _____		
	LESS: Employer sponsored plans for govt. employees	EGP--	\$ _____		
	Total Taxable Other Health	TOP--	\$ _____	X	<u>1.6%</u> = \$ _____

2. GROSS PREMIUM TAX DUE: \$ _____

3. *DEDUCTIONS/CREDITS**

- a) Ad valorem taxes paid on property owned & occupied as the insurer's principal office in Alabama \$ _____
- b) Ad valorem taxes paid on property in Alabama at least 50% occupied by insurer \$ _____
- c) Ad valorem taxes paid directly or in the form of rent to a third-party landlord on the insurer's offices in Alabama, apportioned by the square foot area occupied by the insurer. \$ _____
- d) All assessments paid during the year to the Alabama Health Insurance Plan
- e) All examination expenses paid to the Alabama Commissioner of Insurance
- f) 60% of Alabama franchise and privilege taxes paid
- g) 20% of Guaranty Fund Assessments for each of 5 years following the year of payment

			\$ _____						
			Total 3a – 3c						
			\$ _____						
			\$ _____						
			\$ _____						
			\$ _____						
			\$ _____						
			\$ _____						
			\$ _____						

4. Total Deductions (lines 3a – 3g) **Totaled---** \$ _____

5. NET PREMIUM TAX DUE (line 2 less line 4; if line 4 is greater than 2, enter zero) \$ _____

6. LESS: Quarterly Premium Tax Payments \$ _____

7. LESS: Prior Year Overpayment \$ _____

8. PREMIUM TAX PAID (line 5 less lines 6 and 7) **PD---** \$ _____

**** Line item 1b-(tax-exempt premium only) requires supporting documentation. A policy run, which can be obtained from the Company's underwriting unit will suffice as documentation.**
***** Lines 3a – 3g require two forms of documentation. If documentation is not included, the deduction will not be allowed. All documentation must include a canceled check or verification of EFT payment. The second form of documentation may include a bill, an assessment, or a tax return.**