INSURANCE TAX RETURN
Life and Accident and Health Companies

State Form 6136 (R7 / 8/94)
Approved by State board of Accounts, 1991

NAIC Number (5 digits)
Federal Identification Number
Calendar year Ended

COMPANY INFORMATION

Company Name	
Address (Street, City, and State)	Zip Code
State of Incorporation	Date of Incorporation

INSTRUCTIONS

1. The Return, which must be typewritten, pertains to Indiana business during the twelve-month period ending December 31. It is due on or before **March 1** and will be **delinquent** after that date.

2. The amount due should be calculated and a check payable to the Indiana Department of Insurance prepared for the amount shown on page 2, line 22 of this return. If preparing multiple returns for the Indiana Department of Insurance, a separate check must be prepared for **each** company.

3. The retaliatory portion, page 2, column 2, is to be completed as if your company were an Indiana company completing the form for your state of incorporation. **Deductions may be made only if your domicilary state allows such deductions for similar Indiana Companies.**

4. Please refer to Indiana Insurance Code 27-1-18-2 for Gross Premium Privilege Tax, and 27-1-20-12 for Retaliatory Provisions. The code is available on Indiana's web site (www.state.in.us/legislative/ic/code/).

5. Attach a completed copy of the Indiana Business page from the Company's Annual Statement to this return and payment.

6. **Do not include with any other filing or Insurance Department Correspondence.** Each Return with original signatures, photocopies are not acceptable, and separate check must be mailed separately to the following address:

INDIANA DEPARTMENT OF INSURANCE
POST OFFICE BOX 5416
INDIANAPOLIS, INDIANA 46255

PREPARER INFORMATION

Name of preparer or contact person	Telephone number ( )

LIFE AND ACCIDENT AND HEALTH INSURANCE COMPANIES		
Company:	Indiana Premium Tax Statement for Year_____	
	Column - 1	Column – 2
PREMIUM & ANNUITY CONSIDERATIONS	Indiana Basis	State of Incorporation Basis
1. Life insurance premium (column 6, Indiana State Page of Annual Statement)	$	$
2. Annuity considerations (column 6, Indiana State Page of Annual Statement)	XXXXXXX	
3. Accident, health and hospitalization premium (column 2, Indiana State Page of Annual Statement)		
4. Reinsurance premiums received on risks located in Indiana		
5. **Total Premium and Annuity Considerations** (Lines 1 – 4)		
DEDUCTIONS		
6. Dividends to policyholders permitted by IC 27-1-18-2		
7. Considerations received for reinsurance of risks within this State from companies authorized to transact business in this State		
8. Other (identify)		
9. Total Deductions		
10. Net taxable insurance premiums, line 5 minus line 9		
11. Domicillary premium tax rate of _____ % x Col.. 2, line 10 (2% for Indiana x Column 1, line 10)		
12.		
13.		
14.		
15. **Totals** (lines 11 thorough 14)		
16. Retaliatory tax due - enter difference between Columns (1) and (2) of line 15 if Column (2) amount exceeds Column (1); otherwise enter '0". (See notes 1 and 2 below)		
17. Sub-total tax (column 1 line 15, plus line 16) less :		
18. Indiana Life and Health Guaranty Association Assessments, credit limited to 20 % of assessment paid. See IC 27-8-8-16 **(Proof of payment must be attached)**		
A. Comprehensive Health Assessment **(Proof of payment must be attached)**		
19. **Total** (line 17 less lines 18 and 18A)		
20. Overpayment prior year, not refunded $		
21. Estimated tax paid:		
April 15		
June 15		
September 15		
December 15		
22. **NET TAX DUE** (line 19 less lines 20 and 21)		

Note 1: Enter and describe other taxes imposed by your state of domicile. Attach completed copies of all state tax returns required by your state of domicile using Indian premiums in calculations prepared on the basis of what an Indiana company would pay your state including assessments.

Note 2: Enter other assessments made by your state of domicile against Indiana companies for which premium tax credit is not given. To be included are assessments such as Fraud Bureau, funding of specialized insurance department services, insurance general operating maintenance expense assessments, etc., show calculations where needed.

The undersigned Treasurer of being first duly sworn upon his/her oath says that this return (including any accompanying schedules and statements) is to the best of his/her knowledge a true, correct and complete statement of the information called for and that proper care has been taken in the preparation of this Return.

State of _____ } SS: County of _____	Signature of Treasurer Signature of Notary Public
Date subscribed and sworn to Notary Public	Printed or typed name of Notary Public
Date Commission expires	County of residence