STATE OF DELAWARE DEPARTMENT OF INSURANCE
2009 ANNUAL FEES ASSESSMENT FORM
FOR THE CALENDAR YEAR 2009, DUE MARCH 1, 2010

Original Report ☐
Amended Report ☐

DPO–HMO–HSC

COMPANY INFORMATION AND MAILING ADDRESS

Company Name: _____

Contact Person: _____

Contact E-mail: _____

Contact Phone and Ext.: _____ Fax: _____

Company Mailing Address: _____

City – State – Country – Zip + 4: _____

Federal E.I.N. #: _____

N.A.I.C. #: _____

N.A.I.C. Group #: _____

State of Domicile (abbr.): _____

Questions should be directed to:
Ann Fletcher
Tax and Fees Coordinator
E-mail: Ann.Fletcher@state.de.us

INSTRUCTIONS

The calendar year 2009 Annual Fees Assessment Form is specifically developed for Dental Plan Organizations (DPO), Health Maintenance Organizations (HMO), and Health Service Corporations (HSC). This form reflects that although these companies are exempt from paying premium taxes to the State of Delaware, direct premiums written must be reported for data purposes and the companies are subject certain annual fees as listed below.

Line 1 – CERTIFICATE OF AUTHORITY RENEWAL FEE References are to Title 18, Delaware Insurance Code

Dental Plan Organizations enter:	$100.00	(§701; §3804(c))
Health Maintenance Organizations enter:	$100.00	(§701; Regulation 58, §6)
Health Service Corporations enter:	exempt	(§6304)

Line 2 – ANNUAL STATEMENT FILING FEE	All companies enter:	$100.00	(§701; §526)
Line 3 – FRAUD PREVENTION BUREAU FEE	All companies enter:	$550.00	(§2415)
Line 4 – TOTAL AMOUNT DUE	Sum Lines 1 through 3. Remit this amount.		

MAIL TO THE ADDRESS BELOW

DO NOT send any tax reports to either of the bank lockbox address that have been in effect for the past several years.

Delaware Insurance Department
Attn: PREMIUM TAX SECTION
841 Silver Lake Blvd.
Dover, DE 19904-2465

REPORT OF PREMIUMS WRITTEN

1.	Direct Premiums Written in Delaware	0.00
2.	LESS Return Premium	0.00
3.	NET Premiums Written	0.00

Enter Return Premium as a negative number for calculation purposes.
NOTE: Although premium is tax exempt, the Department must collect this data.

ANNUAL FEES

1.	Certificate of Authority Renewal Fee:	0.00
2.	Annual Statement Filing Fee:	0.00
3.	Fraud Prevention Bureau Annual Fee:	0.00
4.	TOTAL AMOUNT DUE:	0.00

AFFIDAVIT	All Premium Tax and Fees Reports shall be verified by the oath or affirmation of the President and Secretary or other responsible officer of the insurer, duly administered by a person authorized to administer oaths.

In the State of _____ County of _____ on this date _____, before me, the subscriber, personally appeared _____ President, and _____ Secretary (or other responsible officers) of the Insurer named above, 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** _____

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

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

SAVE PRINT