



**STATE OF DELAWARE  
DEPARTMENT OF INSURANCE  
INDEPENDENT PROCUREMENT PREMIUM TAX REPORT**

Original Report

Amended Report

**SELF-PROCURED**

All statutory references are to Title 18, Delaware Insurance Code.

**THIS REPORT MUST BE COMPLETED AND FILED WITH THE DELAWARE INSURANCE DEPARTMENT WITHIN 30 DAYS OF PROCUREMENT OF ANY INSURANCE PURCHASED FROM AN UNAUTHORIZED INSURER WITHOUT THE INVOLVEMENT OF A SURPLUS LINES BROKER.**

**Independent Procurement Statement**

I have been unable to procure the insurance coverage described herein from licensed insurers, which are authorized in Delaware to transact the class of insurance involved, and which accept, in the usual course of business, insurance on risks of the same class as the risk described below; or I was not able to procure from licensed companies the full amount of insurance needed. Having been unable to secure such coverage, I have resorted to obtaining coverage with companies not licensed in the State of Delaware and therefore not under the jurisdiction of the Delaware Insurance Department.

The amount of insurance purchased from the unauthorized insurer(s) is only the excess coverage. Furthermore, this insurance was not purchased from an unauthorized insurer for the purpose of securing more favorable premium rates or policy terms than would be accepted by an authorized insurer.

I understand that the unauthorized insurance company is not a member of the Delaware Insurance Guaranty Association and that Chapter 42 of the Delaware Insurance Code is not applicable to claimants or insureds of this company.

**INSURANCE COMPANY NAME**

**NAIC #** (obtain from Insurer)

**POLICY NUMBER**

**INSURED POLICYHOLDER NAME AND MAILING ADDRESS**

Company Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_  
 Email Address \_\_\_\_\_

Federal EIN: \_\_\_\_\_ ◀ **IMPORTANT**

**POLICY DETAILS**

Effective Date \_\_\_\_\_ to \_\_\_\_\_  
MM/DD/YYYY Format MM/DD/YYYY Format

**TAX PREPARER NAME AND ADDRESS** (if different)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_  
 Email Address \_\_\_\_\_

**TYPE OF INSURANCE**

**DESCRIPTION OF COVERAGE**

**AMOUNT(S)/LIMIT(S) OF INSURANCE**

**PREMIUM TAX CALCULATION**

Gross Premium: \_\_\_\_\_  
**LESS** Return Premium: \_\_\_\_\_  
 Net Taxable Premium: \_\_\_\_\_  
 DE Tax Rate (2% per § 1917): \_\_\_\_\_  
 Total Premium Tax Due: \_\_\_\_\_ ◀ Pay this amount

**MAIL PAYMENT AND THIS FORM TO:**

**Delaware Insurance Department  
Attn: PREMIUM TAX SECTION  
841 Silver Lake Blvd.  
Dover, DE 19901-2465**

*Make checks payable to Delaware Insurance Department*

Briefly explain how this insurance was solicited. \_\_\_\_\_

**AFFIDAVIT**

***I hereby verify that the information contained in this report is a true and correct statement of surplus lines insurance directly procured by me covering risks located in the state of Delaware as described herein.***

Sworn to and subscribed before me this date.

Signed this date: \_\_\_\_\_

Sign Here

*Printed Name of Insured or Insured's Officer*

*Signature of Insured or Insured's Officer*

Sign Here

*Affiant's Title*

*Signature Notary Public*

*Notary Seal*

Direct any questions to: [Ann.Fletcher@state.de.us](mailto:Ann.Fletcher@state.de.us)