DELAWARE DEPARTMENT OF INSURANCE

Sponsored Captive Company and Protected Cell
2010 Annual Insurance Premium Tax and Fees Report
GENERAL INFORMATION AND INSTRUCTIONS
(References are to Title 18, *Delaware Insurance Code*)

Attach a copy of State Page and Schedule T *or* Page 3 Income Statement and Page 5 Premium Schedule to this tax report.

COMPANY INFORMATION AND MAILING ADDRESS

Complete all Company Information. List the address and contact person to whom annual tax and/or fees information or questions should be directed. IMPORTANT: The Sponsored Captive Company Name, EIN and NAIC # must be entered at the top of Page 2.

PART 1 WFC-1 COMBINED PREMIUM TAX SUMMARY FOR CALENDAR YEAR 2010 INSTRUCTIONS

All premium and tax information reported on Working Form C-1 is taken from Working Form C-2, the Protected Cell Premium Tax Report. Sum the amounts listed on each line of WFC-2 for all Protected Cells affiliated with the reporting Sponsored Captive Company. Enter the summed totals on Lines 1 through 5.

Enter the total number of Protected Cells affiliated with the reporting Sponsored Captive Company on line as indicated.

Line 1	Enter the total amount of gross direct premiums written as calculated by adding the amounts listed on Line 5 of WFC-2 for all affiliated Protected Cells.
Line 2	Enter the total amount of assumed reinsurance premiums as calculated by adding the amounts listed on Line 8 of WFC-2 for all affiliated Protected Cells.
Line 3	Enter the total amount of premium tax on gross direct premiums written as calculated by adding the amounts listed on Line 7 of WFC-2 for all affiliated Protected Cells.
Line 4	Enter the total amount of premium tax on assumed reinsurance premiums as calculated by adding the amounts listed on Line 10 of WFC-2 for all affiliated Protected Cells.
Line 5	TOTAL PREMIUM TAX AMOUNT: Sum Line 3 plus Line 4. Should equal the sum of the amounts listed on Line 11 of WFC-2 for all affiliated Protected Cells.
Line 6	Add Certificate of Authority Renewal Fee for Sponsored Captive Company: $300.00 per § 6903 (d) IMPORTANT: Incorporated Protected Cells that hold an individual license must pay the $300.00 Renewal Fee for each Cell. Multiply the number of incorporated protected cells by $300.00 and add the total to the $300.00 fee for the Sponsored Captive Company.
Line 7	TOTAL TAX AND FEES AMOUNT: Sum Line 5 plus Line 6
Line 8	Enter total amount of quarterly prepayments made during the year (if applicable). Subtract from Line 7. Enter as a negative number.
Line 9	PREMIUM TAX AND FEES DUE: Pay this amount.
Line 10	REFUND – amount of overpayment. The Insurance Department will issue a refund check to the company. DO NOT apply refund amount to any future premium tax liabilities.

AFFIDAVIT

Enter information pertinent to the filing of the tax report. 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. After obtaining required signatures, scan this form into PDF format and upload into OPTins. Be sure the signatures and notary seal are clearly visible on the image. Please note: digital signatures are accepted.

PART 2 WFC-2 PROTECTED CELL PREMIUM TAX REPORT INSTRUCTIONS

IMPORTANT: For calculation purposes, when entering amounts in tax forms, enter any credits, negative premium, or subtracted amounts, etc. as a NEGATIVE NUMBER. Remember: Tax amounts may not be less than zero. If "0", or less than "0", enter "0".

INSTRUCTIONS: Complete one section of this form for each Captive Protected Cell that is affiliated with the reporting Sponsored Captive Company. After completion of each section, sum the Taxable Premiums amount from Line 5 for all of the Protected Cells and enter the total amount on Line 1 of WFC-1. Follow the same procedure and enter summed amounts from other Lines for all the Protected Cells on WFC-1: Enter Line 7 to WFC-1 Line 3, Line 8 to WFC-1 Line 2, Line 10 to WFC-1 Line 4, and Line 11 to WFC-1 Line 5. Follow the instructions for each Line as listed below.
IMPORTANT: Per 18 Del. C. § 6914(c), each Protected Cell is subject to the Minimum Tax of $5,000.00. When completing the section for each Protected Cell, if the sum of Line 7 plus Line 10 is less than $5,000 for the Protected Cell, enter the minimum tax amount of $5,000 on Line 11.

Enter the Name, EIN and NAIC # for the Sponsored Captive Company with which the Protected Cells are affiliated at top of page.

Lines 1, 2 and 3	Enter all Direct Premiums collected or contracted for during the calendar year on policies or contracts of insurance written. Deduct amounts paid to policyholders as return premiums with respect to such preceding year only. Deduct only dividends or distributions of unabsorbed premiums or premium deposits returned or credited to policyholders. Do not include annuities.
Line 4	Enter all Excess Workers' Compensation and Employers' Liability Premiums written.
Line 5	**TOTAL DIRECT WRITTEN PREMIUM**: Sum Lines 1 through 4
Line 6	Tax Rate: Multiply Line 5 by .002. (Per § 6914, each protected cell of a sponsored captive insurance company shall pay a tax at the rate of 2/10 of 1% on each dollar of direct premium written)
Line 7	**TOTAL Direct Written Premium Tax** up to a maximum tax of $125,000 per § 6914. If greater than $125,000.00, enter $125,000.00.
Line 8	Enter Total Assumed Reinsurance premiums collected or contracted for during the calendar year on policies or contracts of insurance written. Do not include direct premiums or assets received in exchange for the assumption of loss reserves and other liabilities of another insurer under common ownership and control if such transaction is part of a plan to discontinue the operations of such other insurer and if the intent of the parties to such transaction is to renew or maintain such business.
Line 9	Tax Rate: Multiply Line 8 by .001. (Per § 6914, each protected cell of a sponsored captive insurance company shall pay a tax at the rate of 1/10 of 1% on each dollar of reinsurance assumed)
Line 10	**TOTAL Assumed Reinsurance Premium Tax** up to a maximum tax of $75,000 per § 6914. If greater than $75,000.00, enter $75,000.00.
Line 11	**TOTAL PREMIUM TAX AMOUNT**: Sum Line 7 plus Line 10. Per §6914(c), if less than $5,000.00, enter minimum tax of $5,000.00.

MAILING INSTRUCTIONS

Mail completed tax form, payment and required attachments to the address listed on Page 2 of the tax form.

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

Make checks payable to *Delaware Insurance Department.*

DELAWARE DEPARTMENT OF INSURANCE
ANNUAL PREMIUM TAX AND FEES REPORT
FOR THE CALENDAR YEAR 2010, DUE MARCH 1, 2011

Original Report ☐
Amended Report ☐

Sponsored and Protected Cell Captive

This calendar year 2010 Annual Premium Tax and Fees Report is specifically designed for a Sponsored Captive Company and the Protected Cells affiliated with the Company. This form has sections on page 2 to record premium and tax information for up to 4 Protected Cells. If there are more Protected Cells affiliated with the reporting Sponsored Captive Company, copy page 2 and attach additional pages as needed. If more than 12 protected cells are affiliated with the sponsored captive company, the information required on Page 2 may be submitted in Excel spreadsheet format as an attachment to the tax form. All data fields in each section must be included in the spreadsheet. All statutory references are to Title 18, Chapter 69 the Delaware Revised Captive Insurance Company Act, enacted July 12, 2005. The revised statute may be viewed at http://delcode.delaware.gov/index.shtml.

TAX DEPARTMENT MAILING ADDRESS AND COMPANY INFORMATION

Sponsored Captive Name:					
Premium Tax Contact Person:					
Contact E-mail:					
Tax Dept. Phone and Ext.:			Fax:		
Tax Department Address:					
City – State – Country – Zip + 4:			U.S.A.		

Federal EIN :	
NAIC #:	
NAIC Group #:	

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

WFC-1 COMBINED PREMIUM TAX SUMMARY FOR CALENDAR YEAR 2010

Number of Protected Cells affiliated with this Sponsored Captive Company: _____

REPORTED PREMIUM Combined from all Protected Cells

		Taxable Premiums
1.	TOTAL – All Gross Direct Taxable Premiums (Sum of Line 5 for all cells listed on Page 2)	
2.	TOTAL – Assumed Reinsurance Premiums (Sum of Line 8 for all cells listed on Page 2)	

PREMIUM TAX, FEES AND/OR CREDITS Combined from all Protected Cells

		Premium Tax and Fees
3.	TOTAL – Direct Premium Tax (Sum of Line 7 for all cells listed on Page 2)	
4.	TOTAL – Assumed Reinsurance Premium Tax (Sum of Line 10 for all cells listed on Page 2)	
5.	TOTAL – PREMIUM TAX AMOUNT (Line 3 plus Line 4) (Should match sum of Line 11 for all cells listed on Page 2)	
6.	Annual Certificate of Authority Renewal Fee for Sponsored Captive Insurance Company Per § 6903(d)	
7.	**TOTAL Tax and Fees for Sponsored Captive Company and all Protected Cells**	
8.	**LESS** – Total premium tax prepayments made during 2010 (Enter as a negative number)	
9.	TOTAL Tax and Fees Due (Lines Line 5 plus Line 6) **Attach payment for this amount.** ➔	
10.	REFUND **IMPORTANT:** A Refund Check will be sent to the Company. **DO NOT APPLY THIS AMOUNT TO FUTURE TAX LIABILITY** ➔	

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 _____ (Enter date (MMDDYYYY)), 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)**

Attach a copy of State Page and Schedule T *or* Page 3 Income Statement and Page 5 Premium Schedule to this tax report.

Sponsored Captive Company Name _____ EIN _____ NAIC # _____

WFC-2

PROTECTED CELL PREMIUM TAX REPORT

Complete one section of this form for each Captive Protected Cell that is affiliated with the reporting Sponsored Captive Company. After completion of each section, sum the Taxable Premiums amount from Line 5 for all of the Protected Cells and enter the total amount on Line 1 of WFC-1. Follow the same procedure and enter summed amounts from other Lines for all the Protected Cells on WFC-1: Enter Line 7 to WFC-1 Line 3, Line 8 to WFC-1 Line 2, Line 10 to WFC-1 Line 4, and Line 11 to WFC-1 Line 5. Follow the instructions for each Line as listed in the General Instructions.
IMPORTANT: Per 18 Del. C. § 6914(c), each Protected Cell is subject to the Minimum Tax of $5,000.00. When completing the section for each Protected Cell, if the sum of Line 7 plus Line 10 is less than $5,000.00 for the Protected Cell, enter the minimum tax amount of $5,000.00 on Line 11.

NOTE: If more than 12 protected cells are affiliated with the sponsored captive company, the information required in WFC-2 may be submitted in spreadsheet format as an attachment to the tax form. All data fields must be included in the spreadsheet.

Protected Cell Name: _____ **Certificate #:** _____

		Premiums		Dividends		Taxable Premiums
1.	Life Premiums		-		=	
2.	Accident and Health Premiums		-		=	
3.	Property, Casualty, Surety and Title Premiums		-		=	
4.	Excess Worker's Compensation & Employer's Liability Premiums					
5.	TOTAL – All Gross Direct Taxable Premiums (sum Lines 1-4)					
6.	Direct Premium Tax Rate (2/10 of 1% per § 6914)					
7.	TOTAL Direct Premium Tax (Line 5 x Line 6)					
8.	Assumed Reinsurance Premiums					
9.	Reinsurance Premium Tax Rate (1/10 of 1% per § 6914)					
10.	TOTAL Assumed Reinsurance Premium Tax (Line 8 x Line 9)					
11.	TOTAL PREMIUM TAX AMOUNT (Line 7 plus Line 10)			**Minimum Tax = $5,000.00**		

Protected Cell Name: _____ **Certificate #:** _____

		Premiums		Dividends		Taxable Premiums
1.	Life Premiums		-		=	
2.	Accident and Health Premiums		-		=	
3.	Property, Casualty, Surety and Title Premiums		-		=	
4.	Excess Worker's Compensation & Employer's Liability Premiums					
5.	TOTAL – All Gross Direct Taxable Premiums (sum Lines 1-4)					
6.	Direct Premium Tax Rate (2/10 of 1% per § 6914)					
7.	TOTAL Direct Premium Tax (Line 5 x Line 6)					
8.	Assumed Reinsurance Premiums					
9.	Reinsurance Premium Tax Rate (1/10 of 1% per § 6914)					
10.	TOTAL Assumed Reinsurance Premium Tax (Line 8 x Line 9)					
11.	TOTAL PREMIUM TAX AMOUNT (Line 7 plus Line 10)			**Minimum Tax = $5,000.00**		

Protected Cell Name: _____ **Certificate #:** _____

		Premiums		Dividends		Taxable Premiums
1.	Life Premiums		-		=	
2.	Accident and Health Premiums		-		=	
3.	Property, Casualty, Surety and Title Premiums		-		=	
4.	Excess Worker's Compensation & Employer's Liability Premiums					
5.	TOTAL – All Gross Direct Taxable Premiums (sum Lines 1-4)					
6.	Direct Premium Tax Rate (2/10 of 1% per § 6914)					
7.	TOTAL Direct Premium Tax (Line 5 x Line 6)					
8.	Assumed Reinsurance Premiums					
9.	Reinsurance Premium Tax Rate (1/10 of 1% per § 6914)					
10.	TOTAL Assumed Reinsurance Premium Tax (Line 8 x Line 9)					
11.	TOTAL PREMIUM TAX AMOUNT (Line 7 plus Line 10)			**Minimum Tax = $5,000.00**		

If there are more affiliated Protected Cells copy this page and attach additional pages as needed.

MAILING INSTRUCTIONS

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

SAVE PRINT