INSURANCE TAX RETURN
Life and Accident and Health Companies

State Form 6136 (R 11/1/12)
Approved by State board of Accounts, 1991

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

COMPANY INFORMATION

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

INSTRUCTIONS

1. The Return is due, at the address listed below, to be received on or before **March 1** and will be **delinquent** after that date. Note: When the due date falls on a holiday or weekend the payment is due on the **preceding** business day.

2. The Return accompanied by the appropriate payment must be sent via: regular U.S. Mail, Certified U.S. Mail, U.S. Postal Express or U.S. Priority Mail. No other methods of mailing may be utilized. No alternative mailing addresses are valid. Any deviations may cause the filing to be delinquent and penalties may be incurred.

3. 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 (http://www.in.gov/legislative/ic/code/title27).

4. 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 state of domicile allows such deductions for similar Indiana Companies.** Please attach all applicable tax statements from your State of Incorporation. Complete the statement(s) based on Indiana Premiums on the basis of what a foreign company would pay in your state (including assessments). Use line 12, 13 or 14 for additional taxes or assessments charged.

5. Attach a completed copy of the Indiana State page from the Company's Annual Statement.

6. All values must be rounded to the nearest dollar amount.

7. **Do not submit the Tax Return with any other type of filing or Insurance Department correspondence.**

8. 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 23 of this return. If preparing multiple returns for the Indiana Department of Insurance, a separate check must be prepared for **each** company. Taxes and fees must be kept separate and may not be combined.

INDIANA DEPARTMENT OF INSURANCE
BANK LOCKBOX
POST OFFICE BOX 577
INDIANAPOLIS, INDIANA 46206-0577

PREPARER INFORMATION

Name of preparer or contact person/Title or Position held	Telephone number
Contact Person's Email Address	Fax #

LIFE AND ACCIDENT AND HEALTH INSURANCE COMPANIES

Company: NAIC#:_____ State of Domicile: _____	Indiana Premium Tax Statement for Year _____ Original Return_____ Amended Return_____	
PREMIUM & ANNUITY CONSIDERATIONS	Column – 1 Indiana Basis	Column - 2 State of Incorporation Basis
1. Life insurance premium (Column 5, line 1 Indiana State Page of Annual Statement)	$	$
2. Annuity considerations (Column 5, line 2 Indiana State Page of Annual Statement)	XXXX	
3. Accident, health and hospitalization premium (column 1, line 26 Indiana State Page of Annual Statement)		
4. Reinsurance premiums received on risks located in Indiana		
5. **Total Premium and Annuity Considerations** (sum of lines 1 through 4)		
DEDUCTIONS		
6. Dividends to policyholders permitted by IC 27-1-18-2(a)(2) (Column 5, lines 6.1 and 6.2 and Column 3, line 26 on the Indiana State page of the Annual Statement)		
7. Considerations received for reinsurance of risks within this State from companies authorized to transact business in this State permitted by IC 27-1-18-2(a)(1)		
8. Other (identify – provide supporting documentation where necessary)		
9. Total Deductions (Lines 6 through 8)		
Additional Assessments/Taxes must be entered on lines 12-14 for column 2 – State of domicile (please describe)		
10. Net taxable insurance premiums, line 5 minus line 9 (if less than zero; enter 0)		
11. a. In Column 1, enter the Indiana tax rate of 1.3% x Column 1, line 10 (if less than zero; enter 0 for Column 1, line 11) b. In Column 2, enter the State of Domicile basis premium tax rate of ___% x Col. 2, line 10		
12.	XXXX	
13.	XXXX	
14.	XXXX	
15. **Totals** (sum of lines 11 through 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 (sum of Column 1, line 15 plus line 16)		
TAX CREDITS (ATTACH SCHEDULE 1 and CREDIT WORKSHEET FOR ASSESSMENTS)		
18. Total Assessment Credit (Total from Schedule 1, Section A)		
19. Total State of Indiana Tax Liability Credits According to IC 6-3 and 6-3.1 (Total from Schedule 1, Section B)		
20. **Total Tax** (line 17 less lines 18 and 19)	**$**	
21. Overpayment prior year, not refunded	$	
22. Estimated tax paid:		
a. April 15	$	
b. June 15	$	
c. September 15	$	
d. December 15	$	
e. Total Estimates paid: (sum of 22a through 22d)	$	
23. NET TAX DUE (line 20 less lines 21 and 22e)	$	

Note 1: Enter and describe other taxes imposed by your state of domicile. **Attach completed copies of all tax returns required by your state of domicile** using Indiana 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.

In accordance with IC 27-1-18-2 (a) the undersigned President and Secretary, being first duly sworn upon their his/her oath say 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.

Signature of President Date

Printed or typed name of President

Signature of Secretary Date

Printed or typed name of Secretary

SCHEDULE 1
(Attachment)

INDIANA INSURANCE PREMIUMS - TAX LIABILITY CREDITS	
Company: _____ NAIC#:_____ State of Domicile: _____	Indiana premium tax statement for year ____ Original _____ Amended Return_____
Section A: ASSESSMENTS	
Indiana Insurance Guaranty Fund Assessments - if taking credit, limited to 20% of assessment paid as set forth in Indiana Code 27-6-8-15. (Proof of assessment and payment must be attached)	**$**
Indiana Life and Health Guaranty Fund Assessments - if taking credit, limited to 20% of assessment paid as set forth in IC 27-8-8-16. (Proof of assessment and payment must be attached)	
Comprehensive Health Association Assessment, as set forth in IC 27-8-10-2.4 (effective 1/1/05), NO new tax credit given on Assessments paid 1/1/05 and thereafter. As set forth in IC 27-8-10-2.4 (b), 10% of unused credit accumulated 12/31/04 and prior may be taken. (Proof of assessment and payment must be attached)	
Total Assessment Credits (sum of this section; enter total on page 2, line 18 for Life or line 14 for P&C)	**$**
Section B: STATE OF INDIANA TAX LIABILITY CREDITS (According to IC 6-3 and 6-3.1)	
Enterprise zone employers; credit; employment expenditures– See IC 6-3-3-10 (provide evidence of qualification & worksheet)	$
Enterprise Zone Loan Interest Credit (provide proof per IC 6-3.1-7-2)	
Industrial Recovery Tax Credit (provide proof per IC 6-3.1-11-16)	
Military Base Recovery Tax Credit (provide proof per IC 6-3.1-11.5-18)	
Economic Development for a Growing Economy Tax Credit (provide proof per IC 6-3.1-13-26)	
Capital Investment Tax Credit (provide proof per IC 6-3.1-13.5-13)	
Computer Equipment Donations Tax Credit (provide proof per IC 6-3.1-15-7)	
Indiana Riverboat Building Credit (provide proof per IC 6-3.1-17-5)	
Community Revitalization Enhancement District Tax Credit (provide proof per IC 6-3.1-19-3)	
Venture Capital Investment Tax Credit (provide proof per IC 6-3.1-24-6)	
Hoosier Business Investment Tax Credit (provide proof per IC 6-3.1-26-13)	
Blended Biodiesel Tax Credits (provide proof per IC 6-3.1-27-10)	
Ethanol Production Tax Credit (provide proof per IC 6-3.1-28-7)	
Coal Gasification Technology Investment Tax Credit (provide proof per IC 6-3.1-29-14)	
Headquarters Relocation Credit (provide proof per IC 6-3.1-30-9)	
Employer Health Benefit Plan Tax Credit (provide proof per IC 6-3.1-31-86)	
Small Employer Qualified Wellness Program Credit (provide proof per IC 6-3.1-31.2-46)	
Hoosier Alternative Fuel Vehicle Manufacturer Tax Credit (provide proof per IC 6-3.1-31.9-12)	
Media Production Expenditure Tax Credit (provide proof per IC 6-3.1-32-19)	
Energy Savings Tax Credit (provide proof per IC 6-3.1-31.5-9)	
School Scholarship Tax Credit (provide proof per IC 6-3.1-30.5-18)	
New Employer Tax Credit (provide proof per IC 6-3.1-33-7)	
Total Tax Liability Credits (sum of this section; enter total on page 2, line 19 for Life or line 15 for P&C)	$

Indiana Department of Insurance

Premium Tax Filings – Credit Worksheet for Guaranty Fund Assessments

NAIC Number: _____

State of Domicile: _____

Company Name: _____

The "Membership Assessment History Report" (Report), previously produced by the Indiana Guaranty Fund Office may be used as proof of payment for credit taken on the Indiana Premium Tax Return if available. The Guaranty Fund office no longer produces this report but past reports will suffice until the credits are utilized in full. For 2005 and subsequent guaranty fund assessments the company must provide the Tax Offset Statement, Assessment/Refund Statement and cancelled check (front and back) for each credit being reported. The proof is required to be submitted each and every year a credit is reported. The Guaranty Fund office may be contacted at 317-636-8204.

To receive credit, the following must be provided:

1. Create a separate worksheet for each type of credit taken. Check (X) appropriate box for type of credit listed.
2. Denote (X) appropriate box for type of credit listed.
3. Calculate all assessments paid, less refunds and enter the total using the date received/refund given from the "Report" or the date posted from the canceled check.
4. List assessments and/or refunds newest (top) to oldest (bottom). The cumulative total for the year in which the assessments or refunds were paid/refunded should be entered in the Amount column with the year paid in the date posted column.
5. Enter twenty percent of the total in the appropriate box according to which year the credit is currently representing.
6. A negative credit is to be included as income and calculated in the sum of total tax due.

NOTE: Proof of payment (canceled check) and Assessment Statement required with worksheet for assessment credit taken.

( ) Worksheet for Indiana Life and Health Guaranty Fund Assessment (20%) *

( ) Worksheet for Indiana Guaranty Fund Assessments (20%) *

* Of the assessments <u>paid</u> in the prior calendar year

Date Posted	Check#	Amount	Year #1	Year #2	Year #3	Year #4	Year #5	Total
								$
								$
								$
								$
								$
Carry Forward Credit (Unused credit from prior year)								$
Total Credit Eligible								$
Credit Used – Report amount on Schedule I (Amount may not exceed tax liability)								$
Credit to carry forward for next year:								$

Indiana Department of Insurance

Premium Tax Filing – Credit Worksheet
for Indiana Comprehensive Health Insurance Association (ICHIA) Assessments

NAIC Number: _____

State of Domicile: _____

Company Name: _____

No tax credit is available for the ICHIA assessments January 1, 2005 and thereafter. ICHIA credits accumulated but not utilized for assessments paid prior to January 1, 2005, may be used at the rate of 10% per year for ten years beginning with the 12/31/07 return. Any refunds issued to the company by ICHIA during 2005 for a true-up of the 2004 assessment year must be deducted from the amount of unused credit.

Requirements and Form Instructions:

1. Proof of payment (front and back of canceled check) along with Assessment Statement required for any unused credit balances.
2. The 2005 Assessment Statement issued as a true up for the 2004 Assessment year must be provided, reflecting any 2004 assessment refunds issued to the company. Any refunds would reduce the amount of unused credit to be carried forward.
3. Line 1, column 1 report the unused credit which was accumulated prior to 12/31/04 (amounts paid) less any refunds issued by ICHIA during 2005.
4. Line 1, columns 2-11 should reflect the allowable credit for each year (column 1 amount multiplied by 10%).
5. Line 2, columns 3-11 should reflect the Carry Forward Credit (line 5 of previous column) for that tax year.
6. Line 3, columns 2-11 should reflect the total of lines 1 and 2.
7. Line 4, columns 2-11 should reflect the total credit used for that tax year, which may not exceed the amount of tax liability. Report this amount on Schedule 1 for the Comprehensive Health Association Assessment credit.
8. Line 5, columns 2-11 should reflect the unused credit unused for that tax year (amount in excess of the tax liability). This amount is not subject to the 10% limitation and should be entered on line 2 in the next tax year.

NOTE: Please note that zero tax credit will be allowed if the documentation identified in #1 and #2 above is not provided.

	1	2	3	4	5	6	7	8	9	10	11
	Credit Balance (accumulated prior to 1/1/2005 but not utilized as credit)	2007 Year 1	2008 Year 2	2009 Year 3	2010 Year 4	2011 Year 5	2012 Year 6	2013 Year 7	2014 Year 8	2015 Year 9	2016 Year 10
1											
2	Carry Forward Credit (Unused available credit from prior year)										
3	Total Credit Eligible										
4	Credit Used - Report amount on Schedule 1 (Amount may not exceed tax liability)										
5	Credit to carry forward (not subject to 10%)										