

PROPERTY & CASUALTY INSURERS

COMPANY NAME: _____ **NAIC Company Code:** _____

Contact: _____ **Telephone:** _____

REQUIRED FILINGS IN THE STATE OF: MONTANA **Filings Made During the Year 2019**

(1) Check -list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
I. NAIC FINANCIAL STATEMENTS								
	1	Annual Statement (8 1/2" x 14")	1	EO	xxx	3/1	NAIC	
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	
	2	Quarterly Financial Statement (8 1/2" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	
	3	Protected Cell Annual Statement	0	0	xxx	3/1	NAIC	
	4	Combined Annual Statement (8 1/2" x 14")	0	EO	xxx	5/1	NAIC	
II. NAIC SUPPLEMENTS								
	11	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	
	12	Actuarial Opinion	1	EO	xxx	3/1	Company	X
	13	Actuarial Opinion Summary	1	N/A	xxx	3/15	Company	X
	14	Bail Bond Supplement	1	EO	xxx	3/1	NAIC	
	15	Combined Insurance Expense Exhibit	1	EO	xxx	5/1	NAIC	
	16	Credit Insurance Experience Exhibit	1	EO	xxx	4/1	NAIC	
	17	Cybersecurity and Identity Theft Insurance Coverage Supplement	1	EO	xxx	4/1	NAIC	
	18	Director and Officer Insurance Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	19	Financial Guaranty Insurance Exhibit	1	EO	xxx	3/1	NAIC	
	20	Insurance Expense Exhibit	1	EO	xxx	4/1	NAIC	
	21	Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit	1	EO	xxx	4/1	NAIC	
	22	Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit Adjustment Form	1	EO	xxx	4/1	NAIC	
	23	Long-Term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	
	24	Management Discussion & Analysis	1	EO	xxx	4/1	Company	
	25	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	26	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	
	27	Premiums Attributed to Protected Cells Exhibit	1	EO	xxx	3/1	NAIC	
	28	Reinsurance Attestation Supplement	1	EO	xxx	3/1	NAIC	
	29	Exceptions to Reinsurance Attestation Supplement	1	N/A	xxx	3/1	Company	
	30	Reinsurance Summary Supplemental	1	EO	xxx	3/1	Company	
	31	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	
	32	Schedule SIS	1	N/A	N/A	3/1	NAIC	
	33	Supplement A to Schedule T	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	34	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	
	35	Supplemental Health Care Exhibit (Parts 1, 2 and 3)	1	EO	xxx	4/1	NAIC	
	36	Supplemental Health Care Exhibit's Allocation Report Supplement	1	EO	xxx	4/1	NAIC	
	37	Supplemental Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	
	38	Supplemental Schedule for Reinsurance Counterparty Reporting Exception – Asbestos and Pollution Contracts	1	EO	xxx	3/1	NAIC	
	39	Trusted Surplus Statement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
III. ELECTRONIC FILING REQUIREMENTS								
	61	Annual Statement Electronic Filing	xxx	EO	xxx	3/1	NAIC	
	62	March .PDF Filing	xxx	EO	xxx	3/1	NAIC	
	63	Risk-Based Capital Electronic Filing	xxx	EO	N/A	3/1	NAIC	
	64	Risk-Based Capital .PDF Filing	xxx	EO	N/A	3/1	NAIC	
	65	Combined Annual Statement Electronic Filing	xxx	EO	xxx	5/1	NAIC	
	66	Combined Annual Statement .PDF Filing	xxx	EO	xxx	5/1	NAIC	
	67	Supplemental Electronic Filing	xxx	EO	xxx	4/1	NAIC	
	68	Supplemental .PDF Filing	xxx	EO	xxx	4/1	NAIC	
	69	Quarterly Statement Electronic Filing	xxx	EO	xxx	5/15, 8/15, 11/15	NAIC	
	70	Quarterly .PDF Filing	xxx	EO	xxx	5/15, 8/15, 11/15	NAIC	
	71	June .PDF Filing	xxx	EO	xxx	6/1	NAIC	
IV. AUDIT/INTERNAL CONTROL RELATED REPORTS								
	81	Accountants Letter of Qualifications	1	EO	N/A	6/1	Company	W
	82	Audited Financial Reports	1	EO	xxx	6/1	Company	W
	83	Audited Financial Reports Exemption Affidavit	1	N/A	N/A		Company	W
	84	Communication of Internal Control Related Matters Noted in Audit	1	EO	N/A	8/1	Company	W
	85	Independent CPA (change)	1	N/A	N/A		Company	W
	86	Management's Report of Internal Control Over Financial Reporting	1	N/A	N/A	8/1	Company	W
	87	Notification of Adverse Financial Condition	1	N/A	N/A		Company	W
	88	Relief from the five-year rotation requirement for lead audit partner	1	EO	N/A	3/1	Company	W
	89	Relief from the one-year cooling off period for independent CPA	1	EO	N/A	3/1	Company	W
	90	Relief from the Requirements for Audit Committees	1	EO	N/A	3/1	Company	W
	91	Request to File Consolidated Audited Annual Statements	1	N/A	N/A		Company	W
	92	Request for Exemption to File Management's Report of Internal Control Over Financial Reporting	1	N/A	N/A		Company	W
V. STATE REQUIRED FILINGS								
	101	Certificate of Compliance	0	0	1	3/1	Domicile	O
	102	Certificate of Deposit	0	0	1	3/1	Domicile	P
	103	Corporate Governance Annual Disclosure***	1	0		6/1	Company	
	104	Annual Statement Montana State Page	1	0	1	3/1	Company	
	105	Filings Checklist Page 1 (with Column 1 completed)	1	0	1	3/1	State	
	106	Genetics Program Charge Form (GP-18)	1	0	1	3/1	State	Q
	107	Form B-Holding Company Registration Statement	1	0	0	4/30	State	
	108	Form F-Enterprise Risk Report ***	1	0	0	4/30	State	
	109	ORSA ****	1	0	0	4/30	Company	

110	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	R
111	MT Med Mal Professional Liability Experience (MMMPL-18)	1	0	1	3/1	State	S
112	Montana Premium Tax Report & Remittance (SAI 28)	1	0	1	3/1	State	
113	Quarterly Premium Tax Forms (SAI 23)	1	0	1	4/15, 6/15, 9/15, 12/15	State	T
114	Report of Insured Montana Residents (RIMR-18)	1	0	1	3/1	State	U
115	Small Employer Group Activity Report (SEHRP-18)	1	0	1	3/1	State	V
116	State Filing Fees	1	0	1	3/1	State	
117	Signed Jurat	0	xxx	1	3/1	NAIC	L

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

***For those states that have adopted the NAIC Corporate Governance Annual Disclosure Model Act, an annual disclosure is required of all insurers or insurance groups by June 1. The Corporate Governance Annual Disclosure is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm.

****For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm.

*****For those states that have adopted the NAIC Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. The ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm

	NOTES AND INSTRUCTIONS (A-N APPLY TO ALL FILINGS)
A	<p>Required Filings Contact Person:</p> <p>Montana Commissioner of Securities and Insurance, Examinations Bureau 406-444-2040 or Fax 406-444-3497 E-mail Addresses: Cheryl Donovan at cdonovan@mt.gov; Michelle Scaccia at mscaccia@mt.gov.</p>
B	<p>Mailing Address:</p> <p>Montana Commissioner of Securities and Insurance Examinations Bureau 840 Helena Avenue Helena, MT 59601</p>
C	<p>Mailing Address for Filing Fees:</p> <p>Mailing address is same as above. The fee of \$1,900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.</p>
D	<p>Mailing Address for Premium Tax Payments:</p> <p>Same as B.</p>
E	<p>Delivery Instructions: Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day.</p> <p>The premium tax return (SAI 28) with attachments and any payment is due March 1. The annual statement Montana State Page should be attached to the tax return.</p> <p>If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. DO NOT combine amounts for groups of companies.</p> <p>Note that the tax return requires all companies remit a check for \$1,900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2018, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2019 quarterly premium tax prepayments.</p> <p>Montana Administrative Rules pertaining to tax payments: <u>6.6.2706 Adjustments</u> (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. <u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. <u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. <u>6.6.2708 Application of Refund</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.</p>
F	<p>Late Filings:</p> <p>The commissioner may impose a fine [Sections 33-2-701(6) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]</p>
G	<p>Original Signatures:</p> <p>Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.</p>
H	<p>Signature/Notarization/Certification:</p> <p>Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers, if a corporation.</p>
I	<p>Amended Filings:</p> <p>See NAIC Annual Statement Instructions for guidance on amended filings.</p>
J	<p>Exceptions from normal filings:</p> <p>Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.</p>
K	<p>Bar Codes (State or NAIC):</p> <p>Montana is not currently using Bar Codes.</p>
L	<p>Signed Jurat:</p> <p>Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is re-filed or amended, a newly completed Jurat page is required.</p>
M	<p>NONE Filings:</p> <p>See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.</p>
N	<p>Filings new, discontinued or modified materially since last year:</p> <p>None of the filings have been discontinued since last year.</p>
O	<p>Certificate of Compliance:</p> <p>Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.</p>
P	<p>Certificate of Deposit:</p> <p>Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders, along with a detailed description, including CUSIP# (if available), par value, and/or amortized value and/or market value for each security listed based on the information maintained by insurer's state of domicile. Due March 1.</p>

Q	<p>Genetics Program Charge Form (GP-18):</p> <p>Pursuant to Section 33-2-712 MCA, an insurer is required to pay a fee of \$1.00 to the Commissioner of Insurance per Montana resident insured under any individual or group disability or health insurance policy on February 1 of each year. Any payment due for Genetics Program Charges should be made by attaching a SEPARATE CHECK FOR THE AMOUNT DUE. A Genetics Program Charge Form is required if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. NO FILING REQUIRED IF NO DATA TO REPORT.</p>
R	<p>Insurance Department Financial Examination Report: This state does not require this filing, if hard copy is filed with the state of domicile and if the report is filed electronically with the NAIC.</p>
S	<p>Montana Medical Malpractice Professional Liability Experience Report: (MMMPL-18)</p> <p>2005 legislation requires this report from all Property/Casualty insurers writing medical malpractice professional liability insurance in Montana [Section 33-23-310, MCA]. Due March 1. NO FILING REQUIRED IF NO DATA TO REPORT.</p>
T	<p>Quarterly Premium Tax Forms and Instructions (SAI 23):</p> <p>Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2019 premium taxes on a quarterly basis on or before the 15th day of the following months: April, June, September, and December.</p> <p><u>6.6.2704 Methods of Calculation</u> (1) Every insurer shall pay its quarterly premium tax obligation as follows:</p> <p>(a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or</p> <p>(b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments.</p> <p><u>6.6.2707 Cessation of Business</u> (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.</p> <p>Include with the 2019 quarterly premium tax remittances a completed voucher form SAI 23. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2019, <u>please return all four voucher forms marked "zero" with the April 15 filing.</u></p> <p>The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.</p>
U	<p>Report of Insured Montana Residents (RIMR-18):</p> <p>This report is required if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. NO FILING REQUIRED IF NO DATA TO REPORT.</p>
V	<p>Small Employer Group Activity Report (SEHRP-18):</p> <p>This report is required if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. NO FILING REQUIRED IF NO DATA TO REPORT.</p>
W	<p>Audited Financial Statements:</p> <p>FOREIGN INSURERS ONLY – Please refrain from submitting the Audited Financial Statements to this office until further notice.</p>
X	<p>Statement of Actuarial Opinion:</p> <p>Domestic insurers are required to submit the actuarial opinion, Due March 1.</p>

**General Instructions
For Companies to Use Checklist**

Please Note: This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic filing is intended to be filing(s) submitted to the NAIC via the NAIC Internet Filing Site which eliminates the need for a company to submit diskettes or CD-ROM to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) (Checklist)

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when submitting information to the state.

Column (2) (Line #)

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings)

Name of item or form to be filed.

The **Annual Statement Electronic Filing** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The **March .PDF Filing** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The **Risk-Based Capital Electronic Filing** includes all risk-based capital data.

The **Risk -Based Capital .PDF Filing** is the .pdf file for risk-based capital data.

The **Supplemental Electronic Filing** includes all supplements due April 1, per the *Annual Statement Instructions*.

The **Supplemental .PDF Filing** is the .pdf file for all supplemental schedules and exhibits due April 1.

The **Quarterly Statement Electronic Filing** includes the complete quarterly statement data.

The **Quarterly Statement .PDF Filing** is the .pdf file for quarterly statement data.

The **Combined Annual Statement Electronic Filing** includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit.

The **Combined Annual Statement .PDF Filing** is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

The **June .PDF Filing** is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

Column (4)(Number of Copies)

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail. If such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) (Due Date)

Indicates the date on which the company must file the form.

Column (6) (Form Source)

This column contains one of three words: "NAIC," "State," or "Company." If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions*.

Column (7) (Applicable Notes)

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

MONTANA COMMISSIONER OF SECURITIES AND INSURANCE



840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

2018
ANNUAL PREMIUM
TAX STATEMENT
FIRE COMPANIES
CASUALTY COMPANIES

Insurer Name			NAIC Number	
Company Mailing Address check if new <input type="checkbox"/>		City	State	Zip Code
Tax Contact Mailing Address check if new <input type="checkbox"/>		City	State	Zip Code
State of Domicile	Tax & Fee Contact Person		Tax Contact Person Telephone Number	
Tax Contact Email Address			Toll Free Telephone Number for Policyholder Inquiries	

SCHEDULE A - PREMIUM TAX CALCULATION

- | | | |
|--|----------|------|
| 1. Total Direct premium income (Ann. Stmt: P/C-pg 19, ln 35, col 1; Health-pg 30, ln 12 & 14, col 1; Title-pg 18, ln 6, col 3) | \$ _____ | [1] |
| 2. Finance and service charges (Ann. Stmt: P/C-page 19 footnote a) | \$ _____ | [2] |
| 3. TOTAL PREMIUMS COLLECTED (add lines 1 and 2) | \$ _____ | [3] |
| 4. Dividends refunded or credited to policyholders (Ann. Stmt.: P/C-page 19, line 35, column 3) | \$ _____ | [4] |
| 5. Federal Exemptions - Medicare Title XVIII/Multi-Peril Crop | \$ _____ | [5] |
| 6. NET PREMIUMS per 33-2-705(1), MCA (line 3 less line 4 and 5) | \$ _____ | [6] |
| 7. PREMIUM TAX per 33-2-705(2), MCA (2.75% of line 6) | \$ _____ | [7] |
| 8. Legal Professional Liability Insurance premium per 33-2-705(2)(b), MCA | \$ _____ | [8] |
| 9. Legal Professional Liability Insurance Premium Tax Differential (2% of Line 8) | \$ _____ | [9] |
| 10. NET PREMIUM TAX (Line 7 less Line 9) | \$ _____ | [10] |

SCHEDULE B - FIRE INSURANCE PREMIUM TAX CALCULATION

Pursuant to Mont. Code Ann. §33-2-705(3), taxes are due and payable on the fire portion of the net direct premiums on risks resident, situated or located in Montana. Amounts in Column II must match the Montana State Page. Amounts in column V are to be derived by multiplying amounts in column II by percentages in column IV. If the percentage you set in column IV is less than the percentage in column III, provide supporting documentation for that percentage. Mont. Admin. Rule 6.6.4801 - 6.6.4803

	I	II	III	IV	V
LINE OF BUSINESS	ANNUAL STMT. PG. 19, COL. 1 DIRECT PREMIUM	PRESUMPTIVELY REASONABLE ALLOCATIONS	ACTUAL % ALLOCATION OF FIRE RISK	DOLLAR AMOUNT OF FIRE PREMIUMS	
11. Fire		100%	100%		[11]
12. Allied Lines		30%			[12]
13. Farmowners Multi Peril		40%			[13]
14. Homeowners Multi Peril		40%			[14]
15.a Commercial Multi Peril (Non-Liability)		50%			[15.a]
15.b Commercial Multi Peril (Liability)		35%			[15.b]
16. Ocean Marine		12%			[16]
17. Inland Marine		15%			[17]
18. Other Private Passenger Auto Liability		9%			[18]
19. Other Commercial Auto Liability		9%			[19]
20. Private Passenger Auto Physical Damage		9%			[20]
21. Commercial Auto Physical Damage		9%			[21]
22. Aircraft		15%			[22]
23. Burglary & Theft		20%			[23]
24. Boiler & Machinery		15%			[24]

- | | | |
|---|----------|------|
| 25. Total Net Fire Premiums (add lines 11 thru 24, column V) | \$ _____ | [25] |
| 26. Tax on Fire Insurance Premiums per 50-3-109(1), MCA (2.5% of line 25) | \$ _____ | [26] |

SCHEDULE C -- CALCULATION OF TOTAL TAXES AND FEES

27.	Premium Tax (from line 10)	\$ _____	[27]
28.	Retaliatory Amount per 33-2-709, MCA (from Schedule E, Line 3 or 4)	\$ _____	[28]
29.	TOTAL (Add lines 27 and 28)	\$ _____	[29]
30.	Montana premium tax quarterly pre-payments	\$ _____	[30]
31.	Overpayments of prior year premium taxes (as confirmed by credit letter)	\$ _____	[31]
32.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2013-2017, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	\$ _____	[32]
33.	Empowerment Zone New Employees – tax credit (include copy of certification from Montana Department of Labor and Industry).	\$ _____	[33]
34.	Gross Deductions (add lines 32 and 33)	\$ _____	[34]
35.	Allowable Deductions (enter the smaller of line 27 or line 34)	\$ _____	[35]
36.	Total payments and credits (add lines 30, 31 and 35)	\$ _____	[36]
37.	If line 29 is larger than line 36, DIFFERENCE is TAX DUE	\$ _____	[37]
38.	Fire Insurance Premium Tax (from Schedule B line 26)	\$ _____	[38]
39.	COMPANIES <u>MUST REMIT \$1,900</u> IN PAYMENT OF ALL MONTANA FEES	\$ _____ \$1,900.00	[39]
40.	EXCEPT COMPANIES WRITING <u>LEGAL PROFESSIONAL LIABILITY PAY \$500 IN LIEU OF \$1,900</u>	\$ _____ \$500.00	[40]
41.	TOTAL REMITTANCE (add lines 37, 38 and 39 <u>or</u> 40)	\$ _____	[41]
42.	If line 36 is larger than line 29, DIFFERENCE is ANNUAL TAX OVERPAYMENT	\$ _____	[42]

OVERPAYMENT must be carried forward and used to offset future quarterly tax payments

The above statement, and attached Schedules D and E, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

TAX RETURN CHECKLIST Did You Remember to:

1. _____ Attach Annual Statement Montana State Page?
2. _____ Include Total Remittance from line 41?
3. _____ Attach documentation for tax credits on lines 32 and 33?
4. _____ Indicate your company's NAIC number on front of the tax form?
5. _____ Attach explanations for any unusual or extraordinary items?
6. _____ Fully complete Schedules D and E and attach them to this statement?


**SCHEDULE D -- RETALIATORY SCHEDULE
ATTACHMENT TO 2018 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA**

	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 6)	_____	_____
2. Tax Rate	2.75%	_____
3. Premium Tax (from Schedule A, Line 7)	_____	_____
4. Less 2% of Legal Professional Liability Insurance premium (from Schedule A, Line 8)	(_____)	_____
5. Net Premium Tax (from Schedule A, Line 10)	_____	_____
6. Certificate of Authority Continuation Fee (the lesser of Schedule C, Line 39 or 40)	_____	_____
7. Annual Statement Filing Fee	N/A	_____
8. Assessment for Insurance Department Operations	N/A	_____
9. Montana Fire Insurance Premium Tax (from Schedule B, Line 26)	_____	N/A
10. Fire Marshal Tax	N/A	_____
11. Other Fire Taxes (explain) _____	N/A	_____
12. Other (explain) _____	N/A	_____
13. Other (explain) _____	N/A	_____
14. Total Montana Taxes & Fees (add lines 5 thru 9, col. A)	_____	XXXXXXXXXXXXX
15. Total State of Domicile Taxes & Fees (add 5 thru 13, col. B)	XXXXXXXXXXXXX	_____

**SCHEDULE E -- CALCULATION OF RETALIATORY TAX
ATTACHMENT TO 2018 ANNUAL PREMIUM TAX STATEMENT - FIRE & CASUALTY COMPANIES
STATE OF MONTANA**

1. Enter Amount from Schedule D, Line 15, Col. B _____
2. Enter Amount from Schedule D, Line 14, Col. A _____
3. If Schedule E, Line 1 is larger than Schedule E, Line 2 enter difference on this line and transfer this amount to Schedule C, Line 28 _____
4. If Schedule E, Line 2 is larger than Schedule E, Line 1, enter \$0 on this line and transfer \$0 to Schedule C, Line 28 _____

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

 <p>MONTANA COMMISSIONER OF SECURITIES AND INSURANCE 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040</p>		<p>PREMIUM TAX REFUND REQUEST FORM</p> <p>6.6.2708, ARM</p>	
Insurer Name			NAIC Number
Mailing Address	City	State	Zip Code
State of Domicile	Contact Person and Telephone Number	FEIN Number	
<p><u>A refund can only be processed if insurer completes the following three items:</u></p> <p><input type="checkbox"/> (1) Insurer must complete the calculation in the box at the right</p> <p><input type="checkbox"/> (2) Insurer attaches a completed W-9 form</p> <p><input type="checkbox"/> (3) Please describe in the space below, the reason for the decrease in estimated premium tax liability for 2019</p>		<p>Method of calculation for refund. Calculation subject to audit by Department</p> <p>A. 2018 Overpayment \$ _____</p> <p>2019 Pre-payment Requirement:</p> <p>B. 100% of 2018 Tax \$ _____ or</p> <p>C. 90% of 2019 Tax * \$ _____</p> <p>1. 2018 Overpayment \$ _____ (A from above)</p> <p>2. Prepayment required \$ _____ (B or C from above)</p> <p>3. Amount of Refund \$ _____ (1 minus 2)</p> <p>* Please explain in left hand column.</p>	
Title of Officer		Name of Officer (Type or Print)	
Date		Signature of Officer	
<p>Subscribed and sworn to before me this _____ day of _____, 20 _____.</p> <p style="text-align: right;">_____ (Notary Public)</p> <p>Residing at _____</p> <p>My commission expires _____</p>			



MONTANA COMMISSIONER OF SECURITIES AND
INSURANCE
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

**GENETICS PROGRAM
CHARGE**

Mont. Code Ann. § 33-2-712

Name of Company

NAIC Number

Mailing Address - Street or PO Box No.

City, State, Zip

Printed Name and Title of Person Completing Form

Telephone Number

To be charged upon every HEALTH OR DISABILITY INSURER, HEALTH SERVICE CORPORATION and the MONTANA STATE GROUP HEALTH SELF-INSURANCE PLAN an annual fee of **\$1.00** for each Montana resident insured under any **individual or group disability or health insurance policy** which includes dental, vision, long-term care and Medicare supplemental insurance, in effect as of February 1 of each year for the purpose of funding the Genetics Program.
FORM DUE MARCH 1 – NO FILING REQUIRED IF NO DATA TO REPORT.

Disability insurance (Section 33-1-207, MCA), including credit disability insurance, is insurance of human beings against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or against disablement or medical expense or indemnity resulting from sickness.

Please provide explanation if fee (or any portion of fee) is not applicable: _____

Number of Montana residents insured under any individual or group health or disability insurance policy in effect as of February 1, 2019 _____

Genetics Charge \$1.00 X 1.00

Total Due . . . (Attach Separate Check for Total Genetics Charge Due) _____

Please make your check payable to: Commissioner of Insurance, State of Montana.

(Printed Name of Officer)

(Title)

(Signature)

State of _____

ss.

County of _____


_____, being duly sworn, says that he/she is an officer of the above named insurance company, and that the foregoing is a full, true and correct statement of the number of Montana residents insured under any individual or group health or disability insurance policy by said company as of February 1, 2019 according to the best of his/her knowledge, information and belief.

Subscribed and sworn to before me this _____ day of _____, 20____.

(Notary Public)

Residing at: _____

Commission Expires: _____

 <p style="text-align: center;"> MONTANA COMMISSIONER OF SECURITIES AND INSURANCE 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040 </p>	<p> Report of Insured Montana Residents under health or disability insurance policies (report due March 1) </p> <p> Mont. Code Ann. § 33-2-704 </p>
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NO FILING REQUIRED IF NO DATA TO REPORT

(Name of Company) (N.A.I.C. #)

(Mailing Address - Street or P.O. Box) (City-State-ZIP)

Section 33-2-704, MCA, requires each insurer providing health or disability insurance to report the number of Montana residents insured under any policy of individual or group health or disability insurance. If your company provides excess of loss or stop loss health or disability insurance, you must also include in your count of covered individuals all Montana residents whose coverage is reinsured in whole or in part by your company. For the purposes of this report, February 1, 2019 should be used as the date for determining the number of Montana residents insured.

An excess of loss or stop loss health or disability insurer may exclude from its count of insured individuals those who have been counted by a primary health or disability insurer or a primary reinsurer. However, the insurer should include in its count the number of individuals it covers under an excess of loss or stop loss health or disability policy for which the individuals have not been counted by a primary insurer. For example, the insurer should include all individuals in its count if excess of loss or stop loss health or disability insurance policies are issued to self-insured employers or plans, multiple employer welfare arrangements, or any other health insurance situations in which first dollar coverage is not provided by a primary insurer.

IMPORTANT! If the number of Montana residents insured by health or disability insurance is not known, provide an estimate as directed on the reverse side of this form.

1. Number of Montana residents insured under any individual or group health or disability insurance policy, including excess of loss or stop loss insurance policies covering health or disability insurance in effect as of February 1, 2019 _____

2. The number of insured lives reported on line 1 above is based on (check one of the following boxes):
 - (a) An actual count of lives insured [] (actual)
 - (b) An estimated count of lives insured, pursuant to the directions on the reverse side of this form [] (estimate)

The foregoing is a full, true and correct statement according to the best of my knowledge, information, and belief.

(Signature of Officer) (Date)

(Printed name and title of officer) (Telephone number)

INSTRUCTIONS FOR ESTIMATING THE COUNT OF INSURED LIVES

The following are guidelines for estimating the number of insured lives in Montana covered by disability insurance (as defined in 33-1-207, MCA) by your company.

For indemnity and HMO disability insurance plans, estimate this number of insured lives by following these steps. A demonstration of the calculation shown in steps 5 and 6 below, shown separately for each disability insurance policy form with premium volume in Montana, must accompany this estimate.

1. Determine the total 2018 disability insurance premium on policies in force during the year, separately for each policy form.
2. For each policy form, determine the "average plan" sold under that form. Plans may be differentiated by deductible/coinsurance level or by other features unique to specific plans. The "average plan" is the plan which most nearly represents the total plans sold under that policy form. This could be the plan with the highest premium volume, a plan between (in value) two or more plans with significant premium volumes, or a plan selected by some other indication that it fairly represents an average of the plans sold.
3. Determine the gross premium for each average plan for each of the following family categories: (a) a single insured individual; (b) an insured individual and spouse; (c) an insured family (that is, an insured individual, the spouse and the children); and (d) an insured individual and the children. Each gross premium should be based on policyholder characteristics which affect the rates (such as age, geographic area, occupation, etc.) that fairly represent an average for the blocks of business covered by the policy. This yields the average gross premium for each family category for each average plan under each policy form, and is represented by "Average Gross Premium_y" in the formula in step 5 below, where "y" refers to one of the four family categories described above.
4. Determine the average distribution of the four family categories above. That is, determine what percent of policies are sold to single individuals, what percent are sold to individual and spouse combinations, and so on. This distribution could change from policy to policy. Each percentage is represented by "Percent_y" in the formula in step 5 below.
5. Calculate the policy form's average premium per insured using the formula:

$$\frac{\sum_{\text{all } y} \text{Average Gross Premium}_y \times \text{Percent}_y}{\sum_{\text{all } y} \text{Average Number of Insureds}_y \times \text{Percent}_y} = \text{Average Premium per Insured}$$

The "Average Number of Insureds_y" for each family category is as follows: 1 for a single insured individual, 2 for an insured individual and spouse, 4 for an insured family and 3 for an insured individual with children.

6. Calculate the total number of insureds for the policy form as follows:

$$\frac{\text{Total In Force Premium}}{\text{Average Premium per Insured}} = \text{Total Number of Insureds}$$

7. The final step is to add all the estimates of number of insureds under each disability insurance policy form to arrive at a single estimate.

Stop loss and excess of loss insurers must contact each entity insured by these coverages to obtain the number of insureds, including dependents, covered under the contract, and add these counts. The insurer must demonstrate the method of determining the total number by submitting the name of each entity covered under the contract and the total number of insureds covered under each. If this number includes insureds which were counted by a primary insurer, submit the number of lives which were already counted, then subtract that number from the total number to get the number of lives not already counted. Be sure to submit all three numbers.



MONTANA COMMISSIONER OF SECURITIES
AND INSURANCE
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

**2018
SMALL EMPLOYER GROUP
ACTIVITY REPORT**

A.R.M. 6.6.5050(6)

NO FILING REQUIRED IF NO DATA TO REPORT
(REPORT DUE MARCH 1)

(Name of Insurance Company)

(N.A.I.C. #)

(Mailing Address - Street or PO Box)

(City - State - Zip)

A.R.M. 6.6.5050(6) of the Small Employer Health Insurance Rules requires reporting of the following information pertaining to health benefit plans covering small groups in Montana. A small group is defined as having employed at least 2 but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. Health benefit plan means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan does not include coverage of excepted benefits if coverage is provided under a separate policy, certificate, or contract of insurance.

1. TOTAL SMALL GROUP MARKET DATA

Total small group premiums written in 2018 \$ _____

Number of employees covered by policies in force at 12/31/18 _____

Number of dependents covered by policies in force at 12/31/18 _____

ON A SEPARATE PAGE, please provide the number of small group contracts, by zip code, in force at 12/31/18.

ON A SEPARATE PAGE, please provide a list of all small employer health benefit plans being actively marketed. Include a list of all form numbers used in connection with these plans, and the date of approval for each form. In the case that a health benefit plan is not being actively marketed, specify the date on which the commissioner was notified that the marketing of this plan would be ceased.

2. HEALTH PLANS NEWLY ISSUED IN 2018

Total number of small group contracts newly issued in 2018 _____

Number of basic health benefit plans newly issued in 2018 _____

Number of standard health benefit plans newly issued in 2018 _____

Number of small group contracts issued to small groups that were uninsured for at least 3 months prior to issue _____

3. HEALTH PLANS RENEWED IN 2018

Total number of small group contracts renewed in 2018 _____

Number of basic health benefit plans renewed in 2018 _____

Number of standard health benefit plans renewed in 2018 _____

Number of small group contracts voluntarily not renewed by employers _____


Number of small group contracts terminated or nonrenewed by carrier in 2018, for reasons other than nonpayment of premium _____

(Type name of person preparing report)

(Telephone # and extension)

(Email address)

6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

 <p>MONTANA COMMISSIONER OF SECURITIES AND INSURANCE 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040</p>		<p>CESSATION OF BUSINESS NOTIFICATION FORM</p> <p>6.6.2707, ARM</p>	
Insurer Name			NAIC Number
Mailing Address		City	State
			Zip Code
State of Domicile	Contact Person and Telephone Number		FEIN #
<p>Explanation of adjustment to quarterly tax pre-payment.</p>			
Title of Officer		Name of Officer (Type or Print)	
Date		Signature of Officer	
<p>Subscribed and sworn to before me this _____ day of _____, 20__.</p> <p style="text-align: right;">_____ (Notary Public)</p> <p>Residing at _____</p> <p>My commission expires _____</p>			

MONTANA COMMISSIONER OF SECURITIES AND INSURANCE
 840 HELENA AVENUE
 HELENA, MONTANA 59601
 (406) 444-2040



MONTANA MEDICAL MALPRACTICE PROFESSIONAL LIABILITY EXPERIENCE REPORT
 Pursuant to 33-23-310, MCA
 Supplement to 2018 Annual Statement for _____ (Company) _____ NAIC #
To be filed March 1 (Surplus Lines Companies, file by April 1)
NO FILING REQUIRED IF NO DATA TO REPORT

REQUIRED INFORMATION - From preceding calendar year	PHYSICIANS	OSTEOPATHS	PODIATRISTS	DENTISTS	OPTOMETRISTS	REGISTERED NURSE	LICENSED PRACTICAL NURSE	ALL OTHER SPECIALTIES	HEALTH CARE FACILITIES as defined by 50-5-101(23), MCA	TOTAL
1. Number of insureds @ December 31										
a. Number of claims-made basis policies										
b. Number of occurrence basis policies										
2. a. Amount of direct premiums paid (written)										
b. Amount of direct premiums earned										
c. Total amount of underwriting expenses (Note in Total column only)	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
3. Number of claims made against insureds										
a. Direct losses paid in 3										
b. Direct Case loss reserves in 3										
c. Direct IBNR loss reserves in 3										
d. Direct ALAE paid in 3										
e. Direct Case ALAE reserves in 3										
f. Direct IBNR ALAE reserves in 3										
4. Number of closed claims with direct loss paid										
a. Total amount of direct losses paid in 4										
5. Number of claims open with no direct loss paid										
6. Number of lawsuits filed against insureds										
a. Number of lawsuit claims closed without settlement										
b. Number of lawsuit claims closed with settlement										
c. Total amount paid in settlements in 6b										
7. Number of lawsuits that went to trial										
a. Number of judgments or verdicts for the plaintiff in 8										
b. Number of judgments or verdicts for the insured in 8										
c. Number of other judgments or verdicts in 8										
8. Total of direct losses paid for claims that went to trial and were closed										



State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: APRIL 15, 2019

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

- 1. 2018 premium tax liability (#10 from tax return) or 90% of anticipated 2019 tax \$ _____
- 2. Less allowable deduction (See instructions on back) \$ _____
- 3. Total 2019 quarterly pre-payment (line #1 - #2) \$ _____
- 4. Enter 25% of the amount on line #3 \$ _____
- 5. Amount of 2018 overpayment applied to this payment (see line #42 of the tax return) \$(_____)
- 6. QUARTERLY AMOUNT REMITTED (#4 - #5) \$ _____
(Instructions on back)

Mail payment to: Montana Commissioner of Securities and Insurance
840 Helena Ave - Helena MT 59601

SAI-23 (11/18)



State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: SEPTEMBER 15, 2019

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

- 1. 2018 premium tax liability (#10 from tax return) or 90% of anticipated 2018 tax \$ _____
- 2. Less allowable deduction (See instructions on back) \$ _____
- 3. Total 2019 quarterly pre-payment (line #1 - #2) \$ _____
- 4. Enter 25% of the amount on line #3 \$ _____
- 5. Amount of 2018 overpayment applied to this payment (see line #42-of the tax return) \$(_____)
- 6. QUARTERLY AMOUNT REMITTED (#4 - #5) \$ _____
(Instructions on back)

Mail payment to: Montana Commissioner of Securities and Insurance
840 Helena Ave - Helena MT 59601

SAI-23 (11/18)



State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: JUNE 15, 2019

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

- 1. 2018 premium tax liability (#10 from tax return) or 90% of anticipated 2019 tax \$ _____
- 2. Less allowable deduction (See instructions on back) \$ _____
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(Instructions on back)

Mail payment to: Montana Commissioner of Securities and Insurance
840 Helena Ave - Helena MT 59601

SAI-23 (11/18)



State of Montana

PROPERTY AND CASUALTY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: DECEMBER 15, 2019

Insurer Name: _____

NAIC # _____ Check Number: _____

QUARTERLY TAX PAYMENT CALCULATION

- 1. 2018 premium tax liability (#10 from tax return) or 90% of anticipated 2019 tax \$ _____
- 2. Less allowable deduction (See instructions on back) \$ _____
- 3. Total 2019 quarterly pre-payment (line #1 - #2) \$ _____
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(Instructions on back)

Mail payment to: Montana Commissioner of Securities and Insurance
840 Helena Ave - Helena MT 59601

SAI-23 (11/18)

QUARTERLY TAX PAYMENT INSTRUCTIONS

Line #2 Instructions

The quarterly amounts should be reduced by subtracting the following **allowable deduction:**

Anticipated 2019 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2014-2018): \$ _____

Total allowable deduction to transfer to line #2 (on front): \$ _____

Other Instructions

Please do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2019.

If insurer deems the total 2019 quarterly pre-payment requirement on line #3 to be a minimal amount (less than \$100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2019.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2019 anticipated premium tax.

If you have any questions, please contact our office at (406) 444-2040.

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