



STATE OF INDIANA
DEPARTMENT OF INSURANCE
State Form 6130(R 5/2009)
Approved by the State Board of Accounts 1997

Initials _____

Date: _____
Check Number: _____
Amount: _____
ROC: _____

For Department Use Only

INDIANA FEE AND RETALIATORY FEE STATEMENT
YEAR ENDING December 31, _____

Instructions:

1. Complete the Fee Statement. Foreign insurers must complete 'State of Domicile Basis' column.
2. For each Company submit an individual check and Fee Statement. A check for the insurance group will not be accepted. The Fee Statement and check filing must be submitted separate from all other filings.
3. Fee Statement and check must be received on or before March 1st, at the address shown on page 2. US Postal Express, US Priority Mail, US Certified Mail or regular US Mail are the **only** methods acceptable (no deviations).

EIN No. _____ State of Domicile _____ NAIC No. (5 digit) _____

Name of Company _____

Type of Company: L&H P&C Title Fraternal HMO LSHMO Farm Mutual Other _____
(Circle one)

Annual Fees (Retaliatory Basis)

	Indiana Basis	State of Domicile Basis
1. Filing of Annual Statement or Consolidated Statement (Enter amount from applicable company type below)	\$ _____	\$ _____
Farm Mutual, L&H, P&C, Reciprocal and Risk Retention Group IC 27-1-3-15(a); \$100		
Fraternal IC 27-11-8-2; \$25		
HMO & LSHMO IC 27-13-27-1(a); IC 27-13-34-23(a); \$50		
Title IC 27-7-3-15; \$20		
2. Renewal of Certificate of Authority Farm Mutual IC 27-5.1-2-15, \$50; Fraternal IC 27-11-8-3, \$25; All other Insurers IC 27-1-3-15, IC 27-13-27-2, IC 27-13-34-23, \$50; Title IC 27-7-3-15, \$5	_____	_____
3. Examining Statement of Condition (<u>Foreign only</u> : Life, Life & Health and P&C) IC 27-1-3-15(a); IC 27-1-18-5, \$5	_____	_____
4. Internal Audit Fee – All Companies licensed to do business in the State of Indiana must pay (a) or (b) .		
a. Internal Audit Fee – Foreign & Domestic; Life & Health, HMO, LSHMO, Property & Casualty, Reciprocal, Title, and Domestic RRG IC 27-1-3-15(d); \$1,000	_____	_____
b. Internal Audit Fee – Farm Mutual & Fraternal IC 27-1-3-15(d); \$250	_____	_____

NAIC No. (5 digit) _____

	Indiana Basis	State of Domicile Basis
5. Other Fees (State of Domicile) Please list: _____	<u>XXXXXXXXX</u>	_____
_____	<u>XXXXXXXXX</u>	_____
_____	<u>XXXXXXXXX</u>	_____
6. Total Fees (Add lines 1 through 5 in each column)	\$ _____	\$ _____
7. Compare Totals from Line 6 and enter the larger amount from either the Indiana or State of Domicile Basis column as Total Remittance Due----->\$ _____		

Please make check payable to: **Indiana Department of Insurance**

Mail check and Statement to: **Indiana Department of Insurance
Bank Lockbox
P. O. Box 636
Indianapolis, IN 46206-0636**

Name of Contact Person/Title _____
Contact Address _____
Contact Telephone Number _____ Contact email address _____ Fax _____
The undersigned treasurer of _____ (Name of Company) being duly sworn upon his/her oath says that this return (including any accompanying schedules and statement) is, to the best of his/her knowledge, a true, correct and complete statement of the information called for, and the proper care has been exercised in the preparation of this statement.
_____ Signature of Treasurer
_____ Printed or typed name of Treasurer
_____ Date Signed