SOUTH DAKOTA DIVISION OF INSURANCE
124 S. EUCLID AVENUE, 2ND FLOOR
PIERRE SD 57501
605-773-3563

CLAIM FORM
FOR REFUND OF PREMIUM TAXES
YEAR ENDING: _____

Company Name: _____
Contact Person: _____ Telephone: _____
NAIC # _____ FEIN # _____
Date: _____

Refund check should be mailed to the following address:

_____
MAILING ADDRESS

_____
CITY STATE ZIP

In accordance with SDCL 10-44-2, I hereby request a refund for the overpayment of premium taxes paid to the state of South Dakota for the period ending _____.

Amount of taxes paid: _____

This claim is being made for the amount of _____. Give a brief summary of the basis for this claim.

_____
_____
_____
_____ .

_____ _____
SIGNATURE OF OFFICER AUTHORIZED TO MAKE SUCH CLAIM TITLE

_____
DATE

Subscribed and sworn to before me, a Notary Public in and for the state of _____ , county of _____ this _____ day of _____ , _____ .

_____
NOTARY SIGNATURE

(SEAL)

_____
COMMISSION EXPIRES