Commonwealth of Kentucky
Office of Insurance
CITY, COUNTY, OR URBAN COUNTY GOVERNMENT QUARTERLY INSURANCE PREMIUM TAX RETURN

Due 30 Days After Each Calendar Quarter

For the Quarter:	**Name of City, County or Urban-County Govt.:**

FILER INFORMATION

Complete either the information for a direct writer or surplus lines broker depending upon the filer type.

Direct Writer	**Surplus Lines Broker** **If coverage was exported pursuant to KRS 304.10, please complete the following:**
Insurance Company Name:	**Individual Broker Name:**
Street Address:	**Name of Broker Firm/Agency:**
City, State, ZIP:	**Street Address:**
Phone:	**City, State, ZIP:**
FEIN:	**Phone:**
NAIC No:	**Office of Insurance License ID No:**

Person responsible for preparing return:

Name:	**Phone:**
Title:	**E-mail Address:**
Street Address:	
City, State, ZIP:	

Line Of Insurance	**(1) Established Tax Rate %**	**(2) Premiums Collected**	**(3) Tax Payable [(1) x(2)]**	**(4) Collection Fee**	**(5) Amount Collected From Policyholders**
Casualty					
Fire & Allied Perils					
Health					
Inland Marine					
Life					
Motor Vehicle					
All Other Risks					
Credits (Form LGT 142)					
Total					

Carrier Listing for Exported Coverage

If reporting as a surplus lines broker pursuant to KRS 304.10, please list the carriers that supplied the coverage for which the premiums and taxes are being reported.*

Carrier Name	NAIC No.	Quarterly Premium Collected	Municipal Taxes Collected	Carrier Name	NAIC No.	Quarterly Premium Collected	Municipal Taxes Collected

*If additional space is needed to list exported carriers, please list the carrier name, NAIC number, and the amount of quarterly premium collected on a separate sheet of paper and submit the information with the completed Form LGT 141.

Certification

I hereby certify that the information provided is an accurate statement of the premiums collected.

(Signature of Person Responsible For Preparing This Return)

(Date)

NOTE: See Filing Instructions