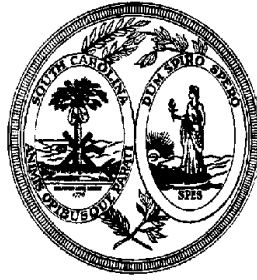


SOUTH CAROLINA DEPARTMENT OF INSURANCE



Post Office Box 100105
Columbia, South Carolina 29202-3105

BROKER'S QUARTERLY PREMIUM TAX PAYMENT

Broker's Social Security Number _____ Date _____

Broker's Name _____ Telephone Number _____

Street _____

City _____ State _____ Zip _____

I do certify that check number _____ in the amount of \$ _____ is for the total amount of Broker's Tax on premiums approved for policies of companies not licensed in South Carolina (endorsements included) for the quarter ended _____.

Signature of Broker _____

PAYMENT MUST BE MADE WITHIN THIRTY (30) DAYS OF CLOSE OF EACH QUARTER.

SCDI Form 2005