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