CT-33-C

2010

New York State Department of Taxation and Finance

Captive Insurance Company Franchise Tax Return

Tax Law – Article 33

All filers must enter tax period:

Amended return ☐   beginning ▮ ☐   ending ▮ ☐

| Employer identification number | File number | Business telephone number ( ) | If you claim an overpayment, mark an **X** in the box ☐ |

| Legal name of corporation | Trade name/DBA |

| Mailing name (if different from legal name above) c/o | State or country of incorporation | Date received (for Tax Department use only) |

| Number and street or PO box | Date of incorporation |

| City   State   ZIP code | Foreign corporations: date began business in NYS |

| NAICS business code number (from federal return) | If address/phone above is new, mark an **X** in the box ☐ | If you need to update your address or phone information for corporation tax, or other tax types, you can do so online. Visit our Web site at *www.nystax.gov* and look for the change my address option. Otherwise, see *Business information* in Form CT-1. | Audit (for Tax Department use only) |
| Principal business activity | | | |

Federal return was filed on (mark an **X** in one):   1120-L ● ☐   1120-PC ● ☐   Consolidated ● ☐   Other: ● ☐ _____

| **A.** Pay amount shown on line 19. Make payable to: ***New York State Corporation Tax*** ◀ Attach your payment here. Detach all check stubs. *(See instructions for details.)* | **A.** | Payment enclosed |

Computation of tax and installment payments of estimated tax

Tax on New York State gross direct premiums

1 First $20,000,000 of gross direct premiums .... ●	× .004 =	●	**1.**
2 $20,000,001-$40,000,000 of gross direct premiums ..... ●	× .003 =	●	**2.**
3 $40,000,001-$60,000,000 of gross direct premiums ..... ●	× .002 =	●	**3.**
4 Excess of $60,000,000 of gross direct premiums .... ●	× .00075 =	●	**4.**

Tax on New York State reinsurance premiums

5 First $20,000,000 of reinsurance premiums .... ●	× .00225 =	●	**5.**
6 $20,000,001-$40,000,000 of reinsurance premiums..... ●	× .0015 =	●	**6.**
7 $40,000,001-$60,000,000 of reinsurance premiums..... ●	× .0005 =	●	**7.**
8 Excess of $60,000,000 of reinsurance premiums.......... ●	× .00025 =	●	**8.**

Computation of tax and estimated tax due

9 Tax due based upon premiums *(add lines 1 through 8)* .... ●	**9.**	
10 Minimum tax	**10.**	5,000 00
11 Tax due *(enter the greater of line 9 or 10)*	**11.**	
First installment of estimated tax for next period:		
12a If you filed a request for extension, enter amount from Form CT-5, line 2 .... ●	**12a.**	
12b If you did not file Form CT-5, see instructions	**12b.**	
13 Total *(add line 11 and line 12a or 12b)*	**13.**	
14 Total prepayments from line 27.. ●	**14.**	
15 Balance *(if line 14 is less than line 13, subtract line 14 from line 13)*	**15.**	
16 Estimated tax penalty *(see instructions; mark an **X** in the box if Form CT-222 is attached)* ● ☐ .... ●	**16.**	
17 Interest on late payment *(see instructions)* .... ●	**17.**	
18 Late filing and late payment penalties *(see instructions)* .... ●	**18.**	
19 **Balance due** *(add lines 15 through 18 and enter here; enter the payment amount on line A above)*	**19.**	
20 Overpayment *(if line 13 is less than line 14, subtract line 13 from line 14)* .... ●	**20.**	
21 Amount of overpayment to be credited to next period	**21.**	
22 **Refund** of overpayment *(subtract line 21 from line 20)*	**22.**	

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Composition of prepayments on line 14 *(see instructions)*

			Date paid	Amount	
23	Mandatory first installment	**23.**			
24a	Second installment from Form CT-400..	**24a.**			
24b	Third installment from Form CT-400..	**24b.**			
24c	Fourth installment from Form CT-400..	**24c.**			
25	Payment with extension request *(from Form CT-5, line 5)*	**25.**			
26	Overpayment credited from prior years...		**26.**		
27	Total prepayments *(add lines 23 through 26; enter here and on line 14)*		**27.**		

Have you been audited by the Internal Revenue Service in the past 5 years?... Yes ☐   No ☐

(if Yes, *list years)* _____

Third – party designee *(see instructions)*	Yes ☐ No ☐	Designee's name *(print)*		Designee's phone number ( )
	Designee's e-mail address			PIN

Certification: I certify that this return and any attachments are to the best of my knowledge and belief true, correct, and complete.

Authorized person	Signature of authorized person		Official title		
	E-mail address of authorized person				Date
Paid preparer use only *(see instr.)*	Firm's name *(or yours if self-employed)*		Firm's EIN	Preparer's PTIN or SSN	
	Signature of individual preparing this return	Address	City	State	ZIP code
	E-mail address of individual preparing this return		Preparer's NYTPRIN	Date	

Attach a copy of your complete federal return and a copy of your *New York Captive Insurance Company Annual Statement* as filed with the New York State Insurance Department.

See instructions for where to file.