



# CT-33-D

(8/15)

Amended return

Department of Taxation and Finance

## Tax on Premiums Paid or Payable To an Unauthorized Insurer

### For Taxable Insurance Contracts with an Effective Date on or after July 21, 2011

Tax Law — Article 33-A

Employer identification number (EIN) or social security number of insured	Insurance policy number		
Name of insured	Calendar quarter and year policy effective/renewed		For Tax Department use only
Number and street or PO box	Jan. - Mar. _____ (yyyy)	Apr. - Jun. _____ (yyyy)	
	Jul. - Sep. _____ (yyyy)	Oct. - Dec. _____ (yyyy)	
City	State	ZIP code	

If the premiums paid are to an affiliated insurance company, provide the information requested below and mark an **X** in the box .....

Name of affiliated insurance company	EIN of affiliated insurance company
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If premiums paid are an endorsement to the original policy, mark an **X** in the box  Effective date of endorsement: \_\_\_\_\_

Type of organization (mark an **X** in one box)

Corporation  Partnership  Individual  Other:

<b>A.</b> Pay amount shown on line 8. Make payable to: <b>Commissioner of Taxation and Finance.</b> Include on the payment your identification number, <b>Form CT-33-D</b> , and the calendar quarter for which you are reporting. (See instructions for details.)	Payment enclosed
	<b>A</b> _____

### Part 1 – Tax computation

1 Premiums paid or payable on taxable insurance contracts (see instructions) .....	<b>1</b>	
2 Tax rate of 3.6% .....	<b>2</b>	0.036
3 Tax due (multiply line 1 by line 2) .....	<b>3</b>	
4 Prepayment .....	<b>4</b>	
5 Balance (if line 3 is greater than line 4, subtract line 4 from line 3) .....	<b>5</b>	
6 Interest on late payment (see instructions) .....	<b>6</b>	
7 Penalties (see instructions) .....	<b>7</b>	
8 Total payment due (add lines 5, 6, and 7 and enter here; enter the payment amount on line A above) .....	<b>8</b>	
9 Overpayment (if line 3 is less than line 4, subtract line 3 from line 4) Credit to next period <input type="checkbox"/> Refund <input type="checkbox"/>	<b>9</b>	

### Part 2 – Insurer information (attach additional sheets if necessary)

Name of insurance company		
Number and street or PO box of insurance company		
City	State	ZIP code

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

<b>Authorized person</b>	Printed name of authorized person	Signature of authorized person	Official title
	E-mail address of authorized person	Telephone number ( )	Date
<b>Paid preparer use only (see instr.)</b>	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 or	Excl. code Date

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