

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

**DIVISION OF INSURANCE**

124 S. Euclid Ave., 2nd Floor, Pierre, South Dakota 57501  
Tel: 605.773.3563 Fax: 605.773.5369 dlr.sd.gov/insurance

**CLAIM FORM FOR REFUND OF PREMIUM TAXES**  
**YEAR ENDING: \_\_\_\_\_**

Company Name: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_  
NAIC # \_\_\_\_\_ FEIN # \_\_\_\_\_  
Date: \_\_\_\_\_

Refund check should be mailed to the following address:

MAILING ADDRESS

CITY

STATE

ZIP

In accordance with SDCL 10-44-2 and 10-55A-6, I hereby request a refund for the overpayment of premium taxes paid to the state of South Dakota for the period ending \_\_\_\_\_.

Amount of taxes paid: \_\_\_\_\_

This claim is being made for the amount of \_\_\_\_\_. Give a brief summary of the basis for this claim.

SIGNATURE OF OFFICER AUTHORIZED TO MAKE SUCH CLAIM

TITLE

DATE

Subscribed and sworn to before me, a Notary Public in and for the state of \_\_\_\_\_, county of \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

NOTARY SIGNATURE

(SEAL)

COMMISSION EXPIRES