



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	
Number and street or PO box		For Tax Department use only	
City		Telephone number	
State		ZIP code	
Jan. - Mar. (yyyy)		Apr. - Jun. (yyyy)	
Jul. - Sep. (yyyy)		Oct. - Dec. (yyyy)	

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
--------------------------------------	-------------------------------------

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: ☐

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

Part 1 – Tax computation

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

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.

Authorized person	Printed name of authorized person		Signature of authorized person		Official title	
	E-mail address of authorized person		Telephone number ()		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 or		Excl. code	Date

475001150094

