MONTANA COMMISSIONER OF SECURITIES AND INSURANCE 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040	2021 ANNUAL MONTANA REINSURANCE ASSOCIATION MEMBER ASSESSMENT *Mont. Code. Ann §33-22-1301, et. seq.*

_____ _____
Name of Company NAIC Number

_____ _____
Mailing Address – Street or PO Box No.

_____ _____
City, State, Zip Code

_____ _____
Printed Name and Title of Person Completing Form Direct Telephone Number/Email Address

Montana Reinsurance Association Member Assessment

Pursuant to Mont. Code. Ann. § 33-22-1313(1), for 2019 and each year thereafter, the Commissioner shall assess each member insurer 1.2% of its total premium volume covering Montana residents, from the prior calendar year, regardless of type of license. For purposes of this assessment, total premium volume may not include premiums that member insurers collect on any coverage issued for excepted benefits as defined in § 33-22-140, MCA. Please see attached Frequently Asked Questions (FAQ).

1. 2020 Direct Premium Income[1] $_____
2. 2020 Premium Adjustments $_____
   - (a) FEHBP Premium Deduction[2] $_____
   - (b) Net ACA Risk Adjustment Accruals & Transfers[3] $_____
   - (c) Other – Explanation Required $_____
3. Net Premium Income [Line 1 + Lines 2(a), 2(b) and 2(c)] $_____
4. Unpaid balance from 2020 Assessment $_____
5. Total Remittance $_____

[1] From Line 1.1 on the **2020 Supplemental Health Care Exhibit – Part 2** for Comprehensive Major Medical, Individual, Small Group and Large Group

[2] From Schedule T Line 27 column 5

[3] From schedule of ACA Receipts, Payments, Receivables & Payables on **2020 Supplemental Health Care Exhibit – Part 1**. Calculation = Current Year ACA Receivables & Payables + Current Year ACA Receipts & Payments – Prior Year ACA Receivables & Payables. If result is positive, report as a deduction and if result is a negative, report as an increase.

PLEASE REMIT YOUR CHECK AND THIS FORM BY JANUARY 31, 2022, TO THE ADDRESS ABOVE. Checks may be made payable to the Montana Commissioner of Securities and Insurance.

Officer Certification

I hereby certify that the information provided herein is a true and correct report of premiums written for Comprehensive Major Medical, Individual, Small Group, and Large Group, and any authorized adjustments, transacted in Montana in 2020 and is in accordance with the requirements of Title 33, chapter 22, part 13, MCA.

Title of Officer _____ **Name of Officer** _____

Date _____ **Signature**_____