

SURPLUS LINES FILING CONFIRMATION FORM

Policy # : \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_

Please enter the risk location state for the surplus lines filing : \_\_\_\_\_

To ensure compliance with the above noted State's surplus lines laws, you are required to provide the requested information for the surplus lines licensee responsible for the collection and remittance of surplus lines taxes, stamping fees or other charges in connection with the placement of this policy. This information may be provided to the State's regulatory authority as confirmation of the proper surplus lines placement of this risk if it is requested.

Name of Surplus Lines Licensee: \_\_\_\_\_ License State: \_\_\_\_\_

Surplus Lines License Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

If you are not located in the policy location state, are you allowed to submit a non-resident filing:  
YES \_\_ NO \_\_

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Total Premium: \$ \_\_\_\_\_ Policy Fee Applied: \$ \_\_\_\_\_

Stamping Fee: \$ \_\_\_\_\_ Other Fees (describe below) \$ \_\_\_\_\_

Surplus Lines Tax: \$ \_\_\_\_\_ Total Amt Paid to State \$ \_\_\_\_\_

State specific Transactional ID Number (if required) \_\_\_\_\_

Description of Fees charged on this Policy: \_\_\_\_\_

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Name of Person Completing this Form: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

With your signature you hereby warrant and represent that the surplus lines licensee indicated above is responsible for the collection and remittance of the surplus lines taxes, stamping fee and/or other charges in connection with the surplus lines placement of this policy.