1995

CT-33-A

New York State Department of Taxation and Finance

Insurance Corporation Combined Franchise Tax Return

Tax Law — Article 33

1995 calendar yr. filers, check box ☐
Other filers enter tax period:
beginning
ending

Employer identification number	File number	If address on return is new, check box *(see instructions)*. ☐	*For office use only*

Mailing Name and Address

Taxpayer's business name

Business name at location below *(if different from business name above)*

c/o

PLACE LABEL HERE

Street or P O Box

City State ZIP code

If your name, employer identification number, address or owner/officer information has changed, you must file Form DTF-95 *(see instructions)*. If no form is enclosed, call 1 800 462-8100 to request one. From areas outside New York State, call (518) 438-1073.

Date received

Audit use

☐ Check box if refund claimed — Complete Form CT-33, lines 32 through 123, for each member of the combined group and file them with this return.

Do you do business, employ capital, own or lease property or maintain an office in the Metropolitan Commuter Transportation District (MCTD)? ☐ Yes ☐ No If you answer *Yes*, you must file Form CT-33-M.

A. Payment — pay amount shown on line 26. Make check payable to: ***New York State Corporation Tax***
Attach your payment here. Payment enclosed

Schedule K — Computation of Tax and Installment Payments of Estimated Tax (see Form CT-33-A-I for assistance)

1	Combined allocated entire net income from line 47	× .09	1	
2	Combined allocated capital from line 49	× .0016	2	
3	Combined alternative base	× .09	3	
4	Minimum tax for parent corporation only		4	250 00
5	Combined allocated subsidiary capital from line 51	× .0008	5	
6	Combined franchise tax *(line 1, 2, 3 or 4, whichever is largest, plus line 5)*		6	
7	Combined life insurance company premiums from line 52, column C	× .008	7	
8	Accident and health premiums from line 53, column C	× .01	8	
9	Other premiums from line 54, column C	× .013	9	
10	Total additional franchise tax *(add lines 7, 8 and 9)*		10	
11	Combined minimum tax for subsidiaries - number of subsidiaries	multiply by $250	11	
12	Total *(add lines 6, 10 and 11)*		12	
13	Limitation on tax (section 1505): premiums from line 55, column C	× .026	13	
14	Tax from line 12 or 13, whichever is less *(see instructions if claiming EDZ or ZEA credits)*		14	
15	Tax credits – ☐ Taxes on certain fire insurance premiums *(enter amount)*			
	☐ Retaliatory Tax ☐ CT-43 ☐ CT-45 ☐ DTF-601 ☐ DTF-601.1 ☐ DTF-602			
	(attach forms; see instructions for Form CT-33, line 12, if more than one credit is claimed)		15	
16	Tax due *(subtract line 15 from line 14; if less than zero, enclose figures in brackets)*		16	
17	State tax surcharge *(multiply line 16 by surcharge rate % ; see instructions)*		17	
18	Total tax and state tax surcharge *(add lines 16 and 17)*		18	
	First installment of estimated tax for next period *(if negative amount, enter "0")*			
19a	If a request for extension was filed, enter amount from Form CT-5.3, line 5		19a	
19b	If Form CT-5.3 was not filed and line 18 is over $1,000, enter 25% (.25) of line 18		19b	
20	Total *(add line 18 and line 19a or 19b)*		20	
21	Total prepayments from line 65		21	
22	Balance *(if line 21 is less than line 20, subtract line 21 from line 20)*		22	
23	Penalty for underpayment of estimated tax *(check box if Form CT-222 is attached ☐ if none, enter "0")*		23	
24	Interest on late payment *(see instructions)*		24	
25	Late filing and late payment penalties *(see instructions)*		25	
26	**Balance Due** *(add lines 22 through 25 - enter payment on line **A** above)*		26	
27	**Overpayment** *(if line 20 is less than line 21, subtract line 20 from line 21)*		27	
28	Amount of overpayment to be credited to next period		28	
29	Balance of overpayment *(subtract line 28 from line 27)*		29	
30	Amount of overpayment to be credited to Form CT-33-M		30	
31	Refund of overpayment *(subtract line 30 from line 29; check refund box above)*		31	
32	Refund of excess retaliatory tax credit *(see instructions; check refund box above)*		32	
33	Combined group issuer's allocation percentage from line 58		33	%

		Parent
Schedule L - Computation of Combined Allocation Percentage		
34 New York premiums from Form CT-33, Schedule B, line 39	**34**	
35 Total premiums from Form CT-33, Schedule B, line 40	**35**	
36 New York premiums percentage *(divide line 34 by line 35)*	**36**	
37 Weighted New York premiums percentage *(multiply line 36 by nine)*	**37**	
38 New York wages from Form CT-33, Schedule B, line 43	**38**	
39 Total wages from Form CT-33, Schedule B, line 44	**39**	
40 New York payroll percentage *(divide line 38 by line 39)*	**40**	
41 Total New York percentages *(add lines 37 and 40)*	**41**	
42 Combined allocation percentage *(divide line 41 by ten)*	**42**	
Schedule M - Computation of Combined Subsidiary Allocation Percentage		
43 New York subsidiary capital from Form CT-33, Schedule C, line 49	**43**	
44 Total subsidiary capital from Form CT-33, Schedule C, line 48, column E	**44**	
45 Combined subsidiary allocation percentage *(divide line 43 by line 44)*	**45**	
Schedule N - Computation of Combined Allocated New York Income		
46 Entire net income from Form CT-33, Schedule F, line 91	**46**	
47 Combined allocated entire net income *(multiply line 46 by line 42; enter here and on line 1)*	**47**	
Schedule O - Computation of Combined Allocated New York Capital		
48 Business and investment capital from Form CT-33, Schedule D, line 59	**48**	
49 Combined allocated capital *(multiply line 48 by line 42; enter here and on line 2)*	**49**	
Schedule P - Computation of Combined Allocated Subsidiary Capital		
50 Subsidiary capital from Form CT-33, Schedule D, line 56	**50**	
51 Combined allocated subsidiary capital *(multiply line 50 by line 45; enter here and on line 5)*	**51**	
Schedule Q - Analysis of Schedule H, Form CT-33		
52 Life insurance company premiums from Form CT-33, Schedule H, line 97, column A *(enter combined total here and on line 7)*	**52**	
Nonlife insurance company premiums:		
53 Accident and health premiums from Form CT-33, Schedule H, line 98, column A *(enter combined total here and on line 8)*	**53**	
54 Other insurance premiums from Form CT-33, Schedule H, line 99, column A *(enter combined total here and on line 9)*	**54**	
Schedule R - Limitation on Tax		
55 Premiums from Form CT-33, line 103 *(enter here and on line 13)*	**55**	
Schedule S - Computation of Issuer's Allocation Percentage		
56 New York gross direct premiums from Form CT-33, line 115	**56**	
57 Total gross direct premiums from Form CT-33, line 116	**57**	
58 Issuer's allocation percentage *(divide line 56 by line 57; enter here and on line 33)*	**58**	

List complete names and employer identification numbers for all members of this combined group *(attach additional pages, if necessary).*

Names	Employer Identification Number
Parent	
Subsidiary #1	
Subsidiary #2	
Subsidiary #3	
Subsidiary #4	
Subsidiary #5	
Subsidiary #6	

You must, within 30 days after the end of the tax year, request permission to file on a combined basis, to include corporations not previously included, or to exclude corporations previously included.

Subsidiary #1	Subsidiary #2	Subsidiary #3	Subsidiary #4	A Total	B Intercorporate Eliminations	C Combined Totals (col. A – col. B)	
Schedule L							
						34	●
						35	●
						36	● %
						37	%
						38	●
						39	●
						40	● %
						41	%
						42	● %
Schedule M							
					●	43	●
					●	44	●
						45	● %
Schedule N							
					●	46	●
						47	●
Schedule O							
					●	48	●
						49	●
Schedule P							
					●	50	●
						51	●
Schedule Q							
						52	
						53	
						54	
Schedule R							
						55	●
Schedule S							
						56	
						57	
						58	%

Composition of Prepayments Claimed on line 21

			Date Paid	Amount
59 Mandatory first installment	59			
60 CT-400 installments	60	(1)		
		(2)		
		(3)		
61 Payment with extension application, Form CT-5.3, line 8	61			
62 Credit from prior years		62		
63 Credit from Form CT-33-M	63	Period		
64 Total prepayments from subsidiaries		64		
65 Total prepayments *(add lines 59 through 64; enter here and on line 21)*		65		

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

Signature of elected officer or authorized person	Official title	Date

Paid Preparer Use Only			
	Firm's name *(or yours if self-employed)*	ID number	Date
	Address	Signature of individual preparing this return	

Mail your return to: **NYS CORPORATION TAX, PROCESSING UNIT, PO BOX 1909, ALBANY NY 12201-1909**