Your Remittance Report must be received no later than April 30, 2020, and annually thereafter ending April 30, 2030.

HEALTHY HOMES FUND
TWELVE DOLLAR ($12) SURCHARGE
PURSUANT TO CONNECTICUT PUBLIC ACT NO. 19-192

ANNUAL REPORT AND REMITTANCE

Section 3 of Public Act No. 19-192 (the "Act") requires each admitted insurer or, for nonadmitted insurers, one or more licensed surplus lines brokers procuring from the nonadmitted insurer, to act on behalf of, and as collection agent of, the Healthy Homes Fund established pursuant to C.G.S. section 8-446 in collecting and remitting to the Connecticut Insurance Department a $12 surcharge on the issuance or renewal of certain insurance policies described below.

- **Types of Insurance Policies.** Imposition of the surcharge applies to policies issued or renewed and effective in this state for the calendar year commencing with 2019:
  - Personal risk insurance coverage for an owned dwelling with four or fewer units, except a mobile home;
  - Coverage for an individual residential unit that is part of a condominium (commonly written on an HO-6 form); and
  - Coverage for an individual residential unit that is part of a common interest community (commonly written on an HO-6 form).

- **Policies Issued or Renewed and Effective.** The surcharge imposed by the Act is required to be assessed annually on applicable insurance policies issued or renewed and effective for the period beginning on 12 AM January 1, 2019 and ending on 11:59 PM December 31, 2029. Subsection (b) of section 3 of Public Act No. 19-192 provides that payment of the surcharge is the obligation of the person that is first listed as an insured under the policy, provided collection and remittance of the surcharge may be effected in such manner as the insurer, insured and any mortgagee may reasonably determine.

- **Due Date.** Insurers and surplus lines brokers are required to remit to the Insurance Commissioner by April 30, 2020, and annually thereafter ending April 30, 2030, surcharges imposed pursuant to the Act for each calendar year. Attached is the Remittance Report Form to be used by insurers and surplus lines brokers.

(Note: The Department does not intend to issue this notice yearly. It is the responsibility of the insurers/surplus line broker to remit this report each year thereafter to comply with the statutory requirements)

NOTE: **A SEPARATE REMITTANCE REPORT IS REQUIRED TO BE FILED FOR EACH ADMITTED INSURER WITHIN A CORPORATE GROUP.**

FOR NONADMITTED INSURERS, ONE OR MORE SURPLUS LINES BROKERS PROCURING FROM THE NONADMITTED INSURER ARE REQUIRED TO FILE A REMITTANCE REPORT.

A null or "zero" report should be filed if no policies subject to the $12 surcharge were issued or renewed during the Period.

HEALTHY HOMES FUND
TWELVE DOLLAR ($12) SURCHARGE
REMITTANCE REPORT FORM

MAIL TO: CONNECTICUT INSURANCE DEPARTMENT—HEALTHY HOMES FUND

For Standard Mail:	***OR***	***For Overnight Mail:***
PO Box 816		*153 Market Street, 7th Floor*
Hartford, CT 06142-0816		*Hartford, CT 06103*

A SEPARATE REMITTANCE REPORT IS REQUIRED TO BE FILED FOR EACH INSURER WITHIN A CORPORATE GROUP. THE INSURANCE DEPARTMENT WILL NOT PROVIDE A SEPARATE INVOICE.

1. POLICY COUNT. The total number of Homeowners policies (HO-2, HO-3 and HO-5); Dwelling Fire policies (DP-1, DP-2 and DP-3); and Condominium policies for residential dwellings (HO-6) which were issued or renewed by the undersigned insurer/broker:

A. Number of homeowners (HO-2, HO-3 and HO-5): _____

B. Number of dwelling fire policies (DP-1, DP-2 and DP-3): _____

C. Number of condominium policies for residential dwellings (HO-6): _____

Total Number of Policies Subject to Surcharge (A+B+C): _____

2. SURCHARGE AMOUNT CALCULATION.

Multiply the Total Number of Policies above by $12: **$_____**

Enclose with this Annual Remittance Report Form a check made payable to **Treasurer, State of Connecticut** for the above amount. Include on the check **the NAIC Company Code and the words "Healthy Homes Fund"**.

**Surplus lines brokers are required to remit the surcharge through OPTins. **

CERTIFICATION

The undersigned, being a duly authorized officer of the insurer named below or a licensed surplus lines broker (as applicable), does hereby certify that the information provided above is true, accurate and complete in all material respects.

NAIC Group Code _____ **Group Name**: _____

NAIC Company Code _____ **Company Name**: _____

Surplus Lines Broker's Name: _____

Broker's License Number: _____

By: _____ **Date**: _____

Print Name:

Title: _____

Phone: _____ **Email**: _____