

(Treasury use)

TERRORISM RISK INSURANCE PROGRAM SCHEDULE A

DECLARATION OF DIRECT EARNED PREMIUM AND CALCULATION OF INSURER DEDUCTIBLE

A. Insurer or Insurer Group Name: _____

B. NAIC Insurer (or Group) Number (or TIN if no NAIC #): _____

- C. Calendar Year: _____
- D. Prior Calendar Year for Calculation of Direct Earned Premium (see instructions for guidance): _____
- E. List all affiliated insurers with premium subject to Terrorism Risk Insurance Act:

F. **Step One:** Direct Earned Premium from the Annual Statement Exhibit of Premiums and Losses (NAIC Statutory Page 14), Column 2 for commercial lines of business, or from another appropriate reporting mechanism. See instructions for guidance.

| Annual S | Statement Line of Business | _ | Direct Earned Premium |
|----------|---|----|-----------------------|
| Line 1 | Fire | \$ | |
| Line 2.1 | Allied Lines | \$ | |
| Line 5.1 | Commercial Multiple Peril (non-liability portion) | \$ | |
| Line 5.2 | Commercial Multiple Peril (liability portion) | \$ | |
| Line 8 | Ocean Marine | \$ | |
| Line 9 | Inland Marine | \$ | |
| Line 16 | Workers' Compensation | \$ | |
| Line 17 | Other Liability | \$ | |
| Line 18 | Products Liability | \$ | |
| Line 22 | Aircraft (all perils) | \$ | |
| Line 27 | Boiler and Machinery | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |
| | | \$ | |



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| Annual Statement Line of Business | _ | Direct Earned Premium |
|-----------------------------------|----|-----------------------|
| | \$ | |
| | \$ | |
| | \$ | |
| | \$ | |
| TOTAL: | \$ | |

G. **Step 2**: Direct Earned Premium included in the numbers reported under Letter F that apply to insurance coverage **not** to be included for purposes of TRIA. See instructions for guidance.

| Annual Statement Line of Business | Direct Earned Premium Not to be Included per TRIA | Reason for Exclusion of Premium |
|--------------------------------------|--|------------------------------------|
| | \$ | |
| | \$ | |
| | \$ | |
| | \$ | |
| | \$ | |
| (add more lines as need | ed) | |
| TOTAL: | \$ | |

H. **Step 3**: Direct Earned Premium, for lines of business included for purposes of TRIA, that were included in the numbers reported under Letter F and were ceded to a state residual market under a servicing carrier arrangement. See instructions for guidance.

| Annual Statement Line of Business | Direct Earned Premium Ceded to Residual Market | Name of Residual Market for Which Insurer Serves as Servicing Carrier | State of Residual Market |
|---|--|---|--------------------------------|
| | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |
| (add more lines as | needed) | | |
| TOTAL: | \$ | | |

I. **Step 4:** Direct Earned Premium for lines of business subject to TRIA that were <u>not</u> included in the numbers reported under Letter F and were distributed to the insurer by commercial lines state residual market entities.

| Annual Statement Line _of Business | Earned Premium Received From Residual Markets | Name of Residual Market Entity | State of Residual Market |
|--|---|-----------------------------------|--------------------------------|
| | \$ | | |
| | \$ | | |
| | \$ | | |
| | \$ | | |

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|---|---|---------------|----------------------------|--------------------------------|--|
| Annual Statement Line of Business | Earned Premium Received From Residual Markets | Name Entit | e of Residual Market / | State of Residual Market | |
| (add more lines as i | \$ | | | | |
| TOTAL: | \$ | | | | |
| J. Complete the foll | owing formula in order to de | etermine th | ne insurer's Calendar Year | deductible. | |
| (F) Step 1 T | otal: \$ |]+ | (I) Step 4 Total: \$ | | |
| – (G) Step 2 T | otal: \$ |]+ | (H) Step 3 Total: | | |
| = | | _ | | | |
| Direct Earned Prem | ium: \$ | | | | |
| X 0.20 Deduct | ible Factor | | | | |
| Insurer Deduc | tible | | | | |

K. Certification

\$

under TRIA

I hereby certify that the Direct Earned Premium data, calculations, and supporting documentation used to determine the insurer deductible are accurate and complete to the best of my information, knowledge, and belief. Any false or fraudulent statements or claims may subject the insurer or signatory to criminal, civil, and/or administrative penalties.

Name

Officer Title

Date

Signature

Notice under the Paperwork Reduction Act

We estimate it will take you about 6.5 hours to complete this form. However, you are not required to provide the information requested unless a valid OMB control number is displayed on the form. Any comments or suggestions regarding this form should be sent to the Terrorism Risk Insurance Program Office, Department of the Treasury, 1500 Pennsylvania Avenue NW, Room 1410 MT, Washington, DC 20220. Do not send completed forms to this address. Submit forms according to instructions provided at https://tripclaims.treas.gov/TRIP/..