

State of Rhode Island Division of Taxation
Form IT-95
 Informational Return of Insurance Companies



16160599990101

Decedent's first name	MI	Last name	Suffix	Decedent's social security number	
Decedent's address - Legal residence (domicile) at time of death		City, town or post office		State	ZIP code

Insurance company information	Name:
	Address:
Date of death	
Type of contract	
Name(s) of payee	
Amount of proceeds if payable in one sum	
Value of proceeds if not paid in one sum	
Provisions of policy with respect to the deferred payments or installments	
Owner of policy if not the insured	

INSTRUCTIONS:

This form must be filed with the Rhode Island Division of Taxation within thirty (30) days of receipt of information of the death of the insured where the payments made or to be made exceed fifty thousand (\$50,000) dollars.

A SEPARATE STATEMENT MUST BE FILED FOR EACH INSURANCE CONTRACT

The undersigned officer of the above named insurance company hereby certifies that this statement is true and correct.

Authorized signature	Print name	Date	Telephone number
Address	City, town or post office	State	ZIP Code
			PTIN