

Company Name: \_\_\_\_\_

Year Ending: \_\_\_\_\_



**OFFICE OF INSURANCE REGULATION**  
***Life & Health Financial Oversight***

**FRATERNAL BENEFIT SOCIETIES**

Name of Society: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Florida Company Code: \_\_\_\_\_

Federal Employer Identification Number: \_\_\_\_\_

For Period Ending: \_\_\_\_\_

**Annual Report Filing Fee**

AMOUNT	TYPE	CLASS	FEE	TR ACCT
\$250	12	50	F	3015

**STAPLE CHECK HERE**

Made payable to the DEPARTMENT OF FINANCIAL SERVICES

Print this page and mail with the check to:

FLORIDA DEPARTMENT OF FINANCIAL SERVICES  
REVENUE PROCESSING SECTION  
Post Office Box 6100  
Tallahassee, FL 32314-6100