

Return this signed application along with all supporting documentation to:

Military Reuse Zone Program  
Arizona Commerce Authority  
333 North Central Avenue, Suite 1900  
Phoenix, AZ 85004

Questions can be directed to  
[cindyg@azcommerce.com](mailto:cindyg@azcommerce.com)

**Arizona Commerce Authority  
MILITARY REUSE ZONE PROGRAM**

**INSURER  
MRZ ANNUAL REPORT<sup>1</sup>**

(For insurers claiming premium tax credits under A.R.S. § 41-1532 (F) and A.R.S. §20-224.04)

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**Section A. Insurer Information**

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Insurer Name	_____		
Mailing Address	_____	Tax Year	_____
City/State/Zip	_____	NAICS #	_____
Contact Name	_____	FEI Number	_____
Email Address	_____	Business Phone	_____
		Business Fax	_____

Name and location of the insurer's operation at the Military Reuse Zone (MRZ). If same as above, write "same as above"

NAME	ADDRESS	CITY/ZIP
_____		

Due Date Of State Premium Tax Return: (Applicant will provide prior notification to Commerce if it will file under an extension or otherwise change the due date.) \_\_\_\_\_

Does the insurer still meet the requirements of A.R.S. § 41-1532? \_\_\_\_\_ Yes \_\_\_\_\_ No

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**Section B. MRZ Benefits Received**

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Did the insurer claim, use or carry forward a **premium tax credit** in this tax year? (If **Yes**, please answer the following) \_\_\_\_\_ Yes \_\_\_\_\_ No

What was the total amount of premium tax credits **claimed** this tax year? \$ \_\_\_\_\_

What was the total amount of premium tax credits **used** this tax year? (Include carry forward amounts and current year credits.) \$ \_\_\_\_\_

What was the total amount of premium tax credits **carried forward**? (After subtraction of amounts used this tax year.) \$ \_\_\_\_\_

<sup>1</sup> This annual report must be filed with the Arizona Commerce Authority within 30 days of filing Arizona tax return with the Department of Insurance.



In each category please list the number of employees for which a tax credit was claimed during this tax year.

1 <sup>st</sup> year of employment	2 <sup>nd</sup> year of continuous employment	3 <sup>rd</sup> year of continuous employment	4 <sup>th</sup> year of continuous employment	5 <sup>th</sup> year of continuous employment

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**Section C. Investment Information**

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What was the investment in fixed assets made by the insurer at the MRZ facility during this tax year?

Buildings/Land	\$ _____
Equipment/Machinery	\$ _____
Total	\$ _____

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**Section D. Employee Information**

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What was the average number of FTEs at the MRZ location during the 4<sup>th</sup> quarter of the previous tax year? \_\_\_\_\_

What was the average number of FTEs at the MRZ location in this tax year? \_\_\_\_\_

How many FTEs does the insurer plan to have at the MRZ location at the end of the next tax year? \_\_\_\_\_

What was the gross payroll (excluding benefits) for all employees at the MRZ location in this tax year? \$ \_\_\_\_\_

What was the average hourly wage paid to all employees at the MRZ location in this tax year? \$ \_\_\_\_\_

What was the gross payroll (excluding benefits) for employees on whom an income tax credit was claimed in this tax year? \$ \_\_\_\_\_

What was the average hourly wage paid to employees on whom an income tax credit was claimed in this tax year? \$ \_\_\_\_\_

In the application or in the last annual report employment goals were stated for this tax year. Please indicate how the above employment data relate to the employment goals established, e.g., met them, exceeded them, failed to meet them because.... (Use an attachment if more space is needed.)

Did the insurer offer health insurance benefits to full-time employees at the MRZ location during this tax year? Yes                  No

If **Yes**, what percentage did the insurer pay? \_\_\_\_\_ %



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**Section E. MRZ Program Evaluation**

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How important a factor was the military reuse zone program in your decision to locate, expand or remain in the zone?

- Very important
- Important
- Not important

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**Section F. Affidavit**

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I, as an officer of the insurer, certify under penalty of perjury that the information contained herein is true and correct according to my best belief and knowledge after a reasonable investigation of the facts.

Further, I attest the insurer continues to meet the eligibility requirements of A.R.S. § 41-1532 and agree to submit a MRZ Annual Report every year the insurer is eligible for benefits whether: claimed, used or carried forward. Failure to submit the requested MRZ report within 30 days of the date of notice will result in revocation of eligibility for MRZ benefits.

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Signature of Authorized Insurer Officer

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Title

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Print Name

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Date