



Reporter's Fed. Id No. _____
 Fiscal Year _____

Department of Labor
 Workers' Compensation Division
 PO Box 488
 Montpelier, VT 05601-0488
 www.labor.vermont.gov

AGGREGATE Annual Reporting Form – Reporting Period 7/01 – 6/30

Carrier: NAIC# _____

Third Party Administrator: for Carrier: _____

Self-Insured:

NAME: _____

ADDRESS: _____

CONTACT PERSON: _____

CONTACT PHONE NUMBER: _____ E-MAIL: _____

Benefit or Expense Paid Out	Total # Claims in which Benefit/Expense was Paid	Total Amount Paid (all claims)	Average benefit/cost per claim
1 Temporary Total Disability - Form 21		\$	\$
2 Temporary Partial Disability – Form 24		\$	\$
3 Permanent Partial Impairment – Form 22		\$	\$
4 Permanent Total Impairment – Form 22		\$	\$
5 Medical		\$	\$
6 Vocational Rehabilitation		\$	\$
7 Fatality (Spouse/dependent) – Form 23		\$	\$
8 Funeral		\$	\$
9 Lump Sum Payments (Form 22, 14 or 15)*		\$	\$
10 Legal Expenses (Defense)		\$	\$
11 TOTAL All Benefits/Expenses Paid		\$	\$

	Total Number
12 First Reports of Injury, Form 1	
13 Fatalities	
14 Medical Only Claims	

15 Attach a list of all employers this report reflects.

INSTRUCTIONS:

1. COMPLETE each blank. Use N/A if appropriate.
2. Provide information for FISCAL YEAR (7/1 – 6/30) ONLY.
3. Do NOT duplicate report. If TPA is used, employer/carrier/TPA should agree upon annual reporter.
4. *Attach itemization of lump sums of Form 14, 15 and 22 if known.