



Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488

DOL Form 16 (Rev. 9/11)
Replaces Former Form 14 and Form 15
State File #:
Ins. Co.. File #
Date of Injury

SETTLEMENT AGREEMENT
Attach any additional conditions, terms, etc.

The injured worker whose address is:

and **insurance carrier **employer agrees that a work injury occurred
on ,20 while worker was employed by
causing the following injury:

and resulting in: [] temporary total disability [] temporary partial disability [] permanent partial disability
[] permanent total disability [] medical only

Beginning on: ,20

That the employee's average weekly wage before the accident was \$
(insurer must have filed a wage statement)

This is an agreement in which the claimant agrees to accept \$, in full and final settlement of :
(list benefits being closed out - indemnity, medical, VR, etc.)
sustained as a result of the accident referred to above.

[] It is agreed that the carrier will continue to furnish:
All reasonable past, present and future medical, hospital, surgical and nursing services and supplies necessary for the treatment
of this injury.
Other (describe):

If payment is to be in a lump sum please complete one of the paragraphs below:

Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$. This lump sum is
compensation for permanent impairment that will affect the claimant for the rest of his/her life. The claimant's remaining life
expectancy is years or months. Therefore, even though paid in a lump sum, claimant's benefit (after
deduction of attorney fees of and expenses of) shall be considered to be
\$ per month beginning on the date of approval of this settlement

OR
Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of \$. Claimant expressly
requests that the lump sum not be prorated as otherwise required by 21 VSA §652(c).

APPROVAL AND REVIEW

This settlement shall not be binding or operative until it is approved by the Commissioner of Labor or designee

Dated at this day of ,20

Insurance Carrier or Employer
By
Employee

Official Title

APPROVED: ,20
Commissioner of Labor/Designee