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DEPARTMENT OF LABOR
WORKERS COMPENSATION DIVISION
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MONTPELIER, VT 05601-0488
(802) 828-2286

DOL Form 21 Rev 9/09
State File No.:
Insurance Co. File No.:
Date of Injury:
FEIN:

AGREEMENT FOR TEMPORARY TOTAL DISABILITY COMPENSATION

IT IS AGREED, between _____, the employee, whose present mailing address is:

Street, Rural Route, Box Number, City, State, Zip

AND _____, the insurance carrier/employer, that on _____ the employee suffered

an accident while in the employ of _____ of the city/town of _____

state of _____ causing the following injury: _____

and resulting in temporary total disability beginning on _____

WEEKLY COMPENSATION RATE

The employee is entitled to a weekly compensation rate of two-thirds (66.667%) of his/her average weekly wage not to exceed his/her weekly net income. S/he is further entitled to an additional \$10.00 per week for each dependent child under 21 years of age provided that the total weekly compensation not exceed the employee's weekly net income.

- A. Claimant's Average Weekly Wage A. \$
B. Weekly Compensation Rate B. \$
(66.667% of A.W.W.; Weekly Net Income; Minimum or Maximum Rate)
C. Number of Dependents multiplied by \$10.00 C. \$
D. Total Weekly Compensation Rate D. \$

DISABILITY

Beginning on the fourth day of disability, the _____ day of _____, and continuing during the period of total disability, the employee shall receive compensation at said rate.

EMPLOYEE OBLIGATION TO REPORT WORK AND EARNINGS

Temporary Total Disability compensation is provided only where an injury causes total disability from any work. By signing this agreement the employee is stating that he or she is not currently working, and that he or she is obligated to report promptly any work, earnings, wages or benefits to the insurance carrier/employer and the department.

Insurance Adjuster Name (Print)

Employee Name (Print)

Insurance Adjuster Signature Date

Employee Signature Date

APPROVED: Date

Commissioner of Labor/Designee