



Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

DOL Form 23 (Rev. 9/09)

State File No.
Ins. Co. File No.
Date of Injury
Fed. ID No.

AGREEMENT FOR COMPENSATION IN FATAL CASES

IT IS AGREED, between
of the dependents of
the deceased employee of
Employer

Employer's Address: Street, City, State, Zip

and
, the insurance carrier/employer

By reason of the fatal accident injury suffered on
, 20
, by the said employee while in the employ of
of the city/town of

in the County of
and State of

causing the following injury

from which death resulted on
, 20

BURIAL EXPENSE

It is agreed that the deceased employee's burial expense shall be borne by the
*insurance carrier/*employer in accordance with the provision of
21 VSA §632.

DEPENDENTS

It is agreed that the following persons were dependent upon the deceased employee for support and by reason of his/her death are entitled to
compensation as provided by law:

Table with 3 columns: Name, Relationship, Date of Birth

WEEKLY COMPENSATION

It is agreed that the employee's average weekly wage for the twenty-six weeks before the injury was
\$
and that said
Dependents are entitled to
% (percent) of said average weekly wage, the sum of
\$
beginning
, 20
and continuing until a change in the condition of dependency occurs, after which the
amount due weekly shall be redetermined. The period of payment shall not exceed the limits set forth in 21 VSA§635, as amended.

APPROVAL AND REVIEW

This agreement or any settlement thereunder shall not be binding or operative unless and until this agreement and such settlement is approved by the
Commissioner of Labor.

Insurance Adjuster Name (Print)

Spouse, Reciprocal Beneficiary, Dependent or Guardian of Dependents (Print)

Insurance Adjuster Signature

Spouse, Reciprocal beneficiary, Dependent or Guardian of Dependents Signature

Official Title Date

Date

APPROVED:
,20

Commissioner of Labor/Designee

*Strike out inappropriate expressions.