VERMONT

**DOL FORM 28** FY-08 Rev 9/09

State File No.** _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

**STATE OF VERMONT**
**DEPARTMENT OF LABOR**
**WORKERS' COMPENSATION DIVISION**

**www.labor.vermont.gov**

# NOTICE OF CHANGE IN COMPENSATION RATE
**(for INJURIES AFTER JULY 1, 1986)**

RE: _____ (Employee) v. _____ (Employer)

Check type of agreement involved: ☐ Temporary Total ☐ Permanent Total ☐ Fatal ☐ Temporary Partial ☐ Permanent Partial

1. Write in the employee's compensation rate effective June 30, 2007. (Not including dependent's benefits.) $ _____

2. Multiply line 1 by 1.040 and write in the result, but not more than the maximum rate of $1,013 or less than the minimum of $338. (see **REMINDER** below)

   ANY CLAIM WHERE THE EMPLOYEE RECEIVED THE MAXIMUM ON JUNE 30, 2007, THE NEW MAXIMUM SHALL BE ENTERED HERE SUBJECT TO EMPLOYEE'S AVERAGE WEEKLY WAGE. $ _____

3. For Temporary Total Disability cases ONLY, multiply the number of dependents under the age of 21 by $10 and write in the result. $ _____

4. Write in the TOTAL of lines 2 and 3. This is the new compensation rate for the year beginning July 1, 2007. $ _____

**REMINDER: FOR INJURIES BETWEEN JULY 1, 1994 AND MAY 25, 2004 THE COMPENSATION RATE CANNOT EXCEED THE WEEKLY NET INCOME. FOR INJURIES AFTER MAY 25, 2004 THE COMPENSATION RATE CANNOT EXCEED 90% OF THE AVERAGE WEEKLY WAGE**

Maximum rate is $1,013 and the minimum rate is $338 (not including dependent's benefits) for the year beginning July 1, 2007.

This is an amendment to the original Temporary Total, Temporary Partial, Permanent Partial, Permanent Total, or Fatal agreement.

_____ Insurance Company or Self-Insured

_____ Date

_____ Claims Adjuster's Signature

_____ Title

_____ Commissioner of Labor & Industry/Designee

_____ Date

Instructions to insurance company or self-insurer: Complete above. Increase the weekly compensation rate beginning July 1, 2007. File **three (3) copies** with the Department of Labor before July 15, 2007. After the change has been approved, provide copies 2 and 3 to the carrier and the claimant.

**If you do not have the state file number please contact the Department of Labor at (802) 828-2286.