

State of Vermont

Workers' Compensation Administration Fund

QUARTERLY ASSESSMENT STATEMENT

Beginning July 1, 2007

DUE: April 30, July 31, October 31 and January 31

FOR QUARTER ENDING _____

Insurer: _____ NAIC Company Code: _____

Group: _____ NAIC Group Code: _____

Federal Tax ID Number (Insurer): _____

1. Total estimated direct premiums written for the quarter being reported: \$ _____

2. Assessment due (Line 1 X .0042): \$ _____

3. Prior Quarter (over) & under payments (explain on reverse if necessary): \$ _____

4. Balance Remitted (Line 2 minus Line 3): \$ _____

OR

5. Credit to be subtracted from next payment: \$ _____

Make checks payable to:

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

The foregoing is an accurate estimate of direct written premiums for the period indicated.

(Signature)

(Date)

Name: _____

Title: _____

Email: _____

Address: _____

Telephone: _____

Fax: _____