Vermont Department of Labor | Workers' Compensation Assessment Fund

Insurer's Reconciliation Statement

Calendar Year: 2015 | DUE: March 15, 2016

Insurer Name: _____ NAIC Company Code: _____

Group Name: _____ NAIC Group Code: _____

1. Direct Premiums Written

Enter the amount of direct premiums written during the period January 1, 2015 through December 31, 2015

This amount should equal what is reported to the Vermont Department of Financial Regulation formerly known as Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), on the company's annual statement [Exhibit of Premiums and Losses (Statutory Page 14 Data), Line 16, Column 1]

1. _____

2. Annual Assessment Due

The Vermont General Assembly establishes the assessment rate annually.

The assessment rate from January 1, 2015 to December 31, 2015 is 1.45%

Multiply the amount on line 1 that was written between January 1, 2015 and December 31, 2015 by .0145

The total annual assessment due is: **2.** _____

3. Quarterly Assessments Previously Submitted

Enter the quarterly assessments due by quarter throughout calendar year 2015.

Amount carried forward from 2014	_____	
1st Quarter	_____	January 1, 2015 – March 31, 2015
2nd Quarter	_____	April 1, 2015 – June 30, 2015
3rd Quarter	_____	July 1, 2015 – September 30, 2015
4th Quarter	_____	October 1, 2015 – December 31, 2015

TOTAL AMOUNT DUE **3.** _____

4. Balance Due

Subtract line 3 from line 2. If the amount is greater than 0, this is the remaining assessment amount due.
If the amount is less than 0, enter the amount on Line 5.

Make checks payable to: **Vermont Department of Labor**

Forward check and this form to: Workers' Compensation Admin Fund
PO Box 488
Montpelier, VT 05601-0488

AMOUNT DUE 4. _____

5. Credit to be applied to next quarterly submission or amount to be refunded

If line 3 is less than zero, this amount will carry forward and be credited toward the next quarterly assessment due. Alternately, this amount may be refunded if requested and the company is no longer writing workers' compensation in Vermont.

CREDIT 5. _____

6. Certification

I certify that the information identified above, and submitted, is true and accurate.

_____ _____

(Signature) (Date)

Name: _____ Telephone: _____

Title: _____ Email: _____

Group Address: _____ Company Address: _____

_____ _____

_____ _____

⇨⇨ Include a copy of "**Exhibit of Premiums and Losses (Statutory Page 14 Data)**" with your submission ⇦⇦