

# Insurer's Reconciliation Statement

Calendar Year: 2016

DUE: March 15, 2017

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, 2016 through December 31, 2016

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, 2016 to December 31, 2016 is 1.45%

Multiply the amount on line 1 that was written between January 1, 2016 and December 31, 2016 by .0145

The total annual assessment due is: 2. \_\_\_\_\_

## 3. Quarterly Assessments Previously Submitted

Enter the quarterly assessments due by quarter throughout calendar year 2016.

Amount carried forward from 2015

1 <sup>st</sup> Quarter	_____	January 1, 2016 – March 31, 2016
2 <sup>nd</sup> Quarter	_____	April 1, 2016 – June 30, 2016
3 <sup>rd</sup> Quarter	_____	July 1, 2016 – September 30, 2016
4 <sup>th</sup> Quarter	_____	October 1, 2016 – December 31, 2016

**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 ⇐⇐