

State of Vermont
Workers' Compensation Administration Fund
QUARTERLY ASSESSMENT STATEMENT

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 .0081): | \$ _____ |
| 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: _____

Telephone: _____

Title: _____

Fax: _____

Email: _____

Address: _____
