VERMONT
VERMONT DEPARTMENT OF LABOR

**Workers' Compensation Division**
**PO Box 488, Montpelier, VT 05601-0488**
www.labor.vermont.gov

**DOL FORM 28** FY-20 Rev 6/19
State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

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

RE: _____ v. _____
(Employee) (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, 2019.
(Not including dependent's benefits.) $ _____

2. Multiply line 1 by 1.032 and write in the result, but not more than the maximum rate of $1,353 or less than the minimum of $451. (see **REMINDER** below)

ANY CLAIM WHERE THE EMPLOYEE RECEIVED THE MAXIMUM ON JUNE 30, 2019, 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, 2019. $ _____

**REMINDER:**

**TEMPORARY TOTAL OR TEMPORARY PARTIAL COMPENSATION SHALL FIRST BE ADJUSTED ON THE FIRST JULY 1 FOLLOWING THE RECEIPT OF 26 WEEKS OF BENEFITS.**

Maximum rate is $1,353 and the minimum rate is $451 (not including dependent's benefits) for the year beginning July 1, 2019.

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, 2019. File with the Department of Labor before July 15, 2019. After the change has been approved please provide a copy to the claimant.