VERMONT

DOL FORM 13 (Rev. 9/09)
State File No. _____
Ins. Co. File _____
Date of Injury _____
Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

REPORT OF BENEFITS AND RELATED EXPENSES PAID

EMPLOYEE: _____

EMPLOYER: _____ NCCI CLASS CODE: _____

INS. CARRIER: _____ CONTACT PERSON: _____

ADJUSTING CO. (if different from carrier): _____

REPORT TOTAL EXPENSES PAID TO DATE FOR THIS CLAIM. Date Completed. _____

VOCATIONAL REHABILITATION

Contractual (VR Vendor) **$** _____ Benefits Paid **$** _____

LEGAL - Defense (Contractual) **$** _____ Plaintiff (Lien) **$** _____

MEDICAL **$** _____

TEMPORARY TOTAL DISABILITY

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____ **$** _____

TEMPORARY PARTIAL DISABILITY

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____

From _____ To _____ @ **$** _____ Total Weeks _____ Days _____ **$** _____

PERMANENT PARTIAL DISABILITY

LUMP SUM ADVANCES Date _____ Amount **$** _____

From _____ To _____ @ **$** _____ Total Weeks _____ **$** _____

PERMANENT TOTAL DISABILITY

From _____ To _____ @ **$** _____ Total Weeks _____

From _____ To _____ @ **$** _____ Total Weeks _____ **$** _____

FATALITY (Spouse/Dependent Benefits)

From _____ To _____ @ **$** _____ Total Weeks _____ **$** _____

FUNERAL (Including payment to the 2nd Injury Fund, if appropriate) **$** _____

SETTLEMENT AGREEMENTS (Check One) 14 ☐ 15 ☐ 16 ☐ **$** _____

EACH BLANK MUST BE COMPLETED. USE N/A WHERE APPROPRIATE.