VERMONT
VERMONT DEPARTMENT OF LABOR

Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488

DOL Form 16 (Rev. 7/14)
State File No.: _____
Ins. Co. File No.: _____
Date of Injury: _____

COMPROMISE AGREEMENT

Claimant, _____ , whose address is _____
and employer/insurance carrier, _____ , hereby agree to a compromise settlement of Claimant's claim for workers' compensation benefits arising out of an alleged work-related accident on _____ while he or she was employed by _____
and in which he or she allegedly suffered the following injury: _____ .

Claimant's average weekly wage before the accident was: $ _____ .

This is an agreement in which Claimant agrees to accept $ _____ in full and final settlement of the following benefits:

☐ Any and all workers' compensation benefits causally related to the above referenced injury
☐ Temporary Total Disability ☐ Permanent Partial Disability ☐ Permanent Total Disability
☐ Temporary Partial Disability ☐ Vocational Rehabilitation ☐ Medical
☐ Other (attach additional sheet if necessary): _____

It is agreed that the employer/insurance carrier will continue to furnish all workers' compensation benefits causally related to the alleged injury referenced above other than those specifically resolved by this Compromise Agreement.

IF payment is to be in a lump sum:

_____ Claimant agrees to accept and the employer/insurance carrier agrees to pay a lump sum of $ _____ . This lump sum is compensation for permanent impairment that will affect Claimant for the rest of his or her life. Claimant's remaining life expectancy is _____ years or _____ months. Therefore, even though paid in a lump sum, Claimant's benefits (after deducting attorney fees of _____ and expenses of _____) shall be considered to be $ _____ per month beginning on the date when this Compromise Agreement is approved.

OR

_____ Claimant agrees to accept and the employer/insurance carrier agrees to pay a lump sum of $ _____ . Claimant expressly requests that the lump sum not be prorated as otherwise required by 21 VSA §652(c).

APPROVAL AND REVIEW

This Compromise Agreement shall not be binding or operative until it is approved by the Commissioner of Labor or designee.

Dated at _____ this _____ day of _____ ,20 _____

_____ Employee

_____ Insurance Carrier or Employer

By: _____
Official Title

APPROVED: _____ , 20 _____

_____ Commissioner of Labor/Designee