DOL Form 23 (Rev. 6/10)

VERMONT
www.labor.vermont.gov

Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

AGREEMENT FOR COMPENSATION IN FATAL CASES

IT IS AGREED, between _____ , *spouse, *reciprocal beneficiary, *dependent, *guardian

of the dependents of _____ the deceased employee of _____
Employer

_____
Employer's Address: Street, City, State, Zip

and _____ , the insurance carrier/employer

By reason of the fatal accident injury suffered on _____ , 20 _____ , by the said employee while in the employ of

_____ of the city/town of _____

in the County of _____ and State of _____

causing the following injury _____

from which death resulted on _____ , 20 _____

BURIAL EXPENSE

It is agreed that the deceased employee's burial expense shall be borne by the *insurance carrier/*employer in accordance with the provision of 21 VSA §632.

DEPENDENTS

It is agreed that the following persons were dependent upon the deceased employee for support and by reason of his/her death are entitled to compensation as provided by law:

Name	Relationship	Date of Birth

WEEKLY COMPENSATION

It is agreed that the employee's average weekly wage for the twenty-six weeks before the injury was $ _____ and that said

Dependents are entitled to _____ % (percent) of said average weekly wage, the sum of $ _____

beginning _____ , 20 _____ and continuing until a change in the condition of dependency occurs, after which the amount due weekly shall be redetermined. The period of payment shall not exceed the limits set forth in 21 VSA§635, as amended.

Day of the week the check will be mailed to the dependent or deposited in the dependent's account _____

APPROVAL AND REVIEW

This agreement or any settlement thereunder shall not be binding or operative unless and until this agreement and such settlement is approved by the Commissioner of Labor.

_____ _____
Insurance Adjuster Name (Print) *Spouse, Reciprocal Beneficiary, Dependent or Guardian of Dependents (Print)*

_____ _____
Insurance Adjuster Signature *Spouse, Reciprocal beneficiary, Dependent or Guardian of Dependents Signature*

_____ _____ _____
Official Title *Date* *Date*

APPROVED: _____ ,20 ____ _____
Commissioner of Labor/Designee

*Strike out inappropriate expressions.