State of Vermont

Workers' Compensation Administration Fund

QUARTERLY ASSESSMENT STATEMENT

DUE: October 31, 2023; January 31, 2024; April 30, 2024 and July 31, 2024

FOR QUARTER ENDING _____

Insurer: _____ NAIC Company Code: _____

Group: _____ NAIC Group Code: _____

1. Total estimated direct premiums written for the quarter being reported: 1. $ _____
2. Assessment due (Line 1 X .015): 2. $ _____
3. Prior quarter over or under payments (explain on reverse): 3. $ _____
4. Balance remitted (Line 2 minus Line 3): 4. $ _____

OR

5. Credit to be subtracted from next payment: 5. $ _____

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: _____

Email: _____

Address: _____

_____

_____