Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286; TDD 800-650-4152

DOL FORM 2 Rev. 5/2024

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

Denial of Workers' Compensation Benefits by Employer or Carrier

THIS FORM IS FILED BY YOUR EMPLOYER'S WORKERS' COMPENSATION INSURANCE COMPANY. They have filed this denial in accordance with Vermont Workers' Compensation Rule 3.2200. Notice must be sent to the injured worker and the Department of Labor. **Supporting evidence must be attached.**

TO:
Claimant's Name: _____

Address: _____ Telephone No.: _____

Employer: _____ Date of Injury: _____

Date Notice of Injury Received by Employer: _____

Body part injured/injuries accepted by carrier: _____

☐ Entire Claim Denied ☐ Indemnity Benefits Denied ☐ Medical Benefits Denied

Check off only the reasons below that apply and give a brief statement of the specific facts you are relying on to support the denial.

☐ **DOCUMENTS ATTACHED**

A. ☐ Medical bill not related to accepted injury (please specify date of bill). _____

B. ☐ No injury arising out of and in the course of employment. _____

C. ☐ No indemnity due. _____

D. ☐ No causal relationship between injury and disability. _____

E. ☐ Medical release (Form 7) not returned by claimant. _____

F. ☐ Treatment is not reasonable, necessary or related to the injury _____

G. ☐ Preauthorization of medical treatment _____

H. ☐ Other (Specify): _____

Issued By:
Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No.: _____

Adjuster Signature: _____ Employer: _____

Date Notice Sent to Claimant: _____

NOTICE and FORM for EMPLOYEE to APPEAL DENIAL

TO APPEAL, COMPLETE THE INFORMATION BELOW **AND** ATTACH EVIDENCE (for example, doctor's notes, emergency room records, any other medical records such as physical therapy, radiology reports, etc. or witness statements) TO SUPPORT THAT YOUR INJURY AROSE OUT OF YOUR WORK. KEEP A COPY OF THIS FORM FOR YOUR RECORDS AND MAIL A COPY OF IT TO BOTH the Department of Labor at the address above and the insurance carrier.

Did you notify your employer/supervisor of the injury/illness? Yes _____ No _____
Identify who you reported the injury to and on what date. _____
Briefly explain how the injury/illness occurred (attach additional pages if necessary):

_____

Did you lose time from work because of the injury? Yes _____ No _____
If yes, on what date did you begin losing time from work? _____
If you have returned to work, indicate the date on which you returned. _____

Please check off and attach documents that you are relying on for your appeal:

- ☐ treatment notes from each office visit you had with any medical provider
- ☐ emergency room records
- ☐ radiology reports (not films)
- ☐ chiropractic records
- ☐ physical therapy notes
- ☐ written clarification from your treating providers as to whether they feel your condition is work-related (strongly recommended).

I am seeking all workers' compensation benefits allowed by law.

_____
Employee Signature Date Signed

_____
Employee Printed Name

_____ _____
Employee Current Mailing Address Employee Personal E-mail Address

_____ _____
Employee Current City, State, Zip Employee Contact Phone Number

If you have further questions please call or office at (802) 828-2286 or check our website at www.labor.vermont.gov