VERMONT
DEPARTMENT OF LABOR

Workers' Compensation Division
PO Box 488, Montpelier, VT 05601-0488
www.labor.vermont.gov

DOL FORM 28A FY-25 Rev 5/24
State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

NOTICE OF CHANGE IN COMPENSATION RATE
(for INJURIES BEFORE JULY 1, 1986)

RE: _____ (Employee) v. _____ (Employer)

Check type of agreement involved:
☐ Temporary Total ☐ Permanent Total ☐ Fatal
☐ Temporary Partial ☐ Permanent Partial

1. Write in the employee's compensation rate effective June 30, 2024.
(Not including dependent's benefits.) $ _____

2. Multiply line 1 by 1.037 and write in the result, but not more than the maximum rate of $1,175 or less than the minimum of $588. $ _____

3. For Temporary Total Disability cases ONLY, multiply the number of dependents under the age of 21 by $20 and write in the result. $ _____

4. Write in the TOTAL of lines 2 and 3. This is the new compensation rate for the year beginning July 1, 2024. $ _____

Maximum rate is $1,175 and the minimum rate is $588 (not including dependent's benefits) for the year beginning July 1, 2024.

This is an amendment to the original Temporary Total, Temporary Partial, Permanent Partial, Permanent Total, or Fatal agreement.

_____ Insurance Company or Self-Insured
_____ Date

_____ Claims Adjuster's Signature
_____ Title

_____ Commissioner of Labor & Industry/Designee
_____ Date

Instructions to insurance company or self-insurer: Complete above. Increase the weekly compensation rate beginning July 1, 2024. File with the Department of Labor before July 15, 2024. After the change has been approved, provide a copy to the claimant.