

# Insurer's Reconciliation Statement

Calendar Year: 2009

DUE: March 15, 2010

Group Name: \_\_\_\_\_

NAIC Group Code: \_\_\_\_\_

Company Name: \_\_\_\_\_

NAIC Company Code: \_\_\_\_\_

Did the company name change during calendar year 2009?  Yes  No **New Company Name:** \_\_\_\_\_

Did the group number change?  Yes  No **New Group Number:** \_\_\_\_\_

During calendar year 2009 was this company involved in a merger?  Yes  No  
If yes, what other NAIC codes were involved? \_\_\_\_\_

### 1. Direct Premiums Written

Enter the amount of direct premiums written  
During the period January 1, 2009 through December 31, 2009

This amount should equal what is reported to the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), on the company's annual statement. [Exhibit of Premiums and Losses (Statutory Page 14 Data), Line 16, Column 1] **1.** \_\_\_\_\_

### 2. Annual Assessment Due

The Vermont General Assembly establishes the assessment rate annually. The assessment rate from January 1, 2009 to June 30, 2009 is .81%  
The assessment rate from July 1, 2009 to December 31, 2009 is .96%  
Multiply the amount on line 1 that was written between January 1, 2009 and June 30, 2009 by .0081. \_\_\_\_\_  
Multiply the amount on line 1 that was written between July 1, 2009 and December 31, 2009 by .0096. \_\_\_\_\_  
This is the total annual assessment due. **2.** \_\_\_\_\_

### 3. Quarterly Assessments Previously Submitted

Enter the quarterly assessments due by quarter throughout calendar year 2009.

Amount carried forward from 2008

1 <sup>st</sup> Quarter	_____	January 1, 2009 – March 31, 2009
2 <sup>nd</sup> Quarter	_____	April 1, 2009 – June 30, 2009
3 <sup>rd</sup> Quarter	_____	July 1, 2009 – September 30, 2009
4 <sup>th</sup> Quarter	_____	October 1, 2009 – December 31, 2009

**TOTAL AMOUNT DUE 3.** \_\_\_\_\_

### 4. Balance Due

Subtract line 3 from line 2. If the amount is greater than 0, this is the remaining assessment amount due.  
If the amount is less than 0, enter the amount on Line 5.

Make Checks Payable to: **Vermont Department of Labor**  
**Forward check, and this form, to:** Workers' Compensation Admin Fund  
PO Box 488  
Montpelier, VT 05601-0488

**AMOUNT DUE 4.** \_\_\_\_\_

### 5. Credit to be applied to next quarterly submission or Amount to be refunded

If line 5 is less than zero, this amount will carry-forward and be credit towards the next quarterly assessment due.  
Alternatively, this amount may be refunded if requested. **CREDIT 5.** \_\_\_\_\_

### 6. Certification

I certify that the information identified above, and submitted, is true and accurate.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

Group Address: \_\_\_\_\_

Company Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

⇒⇒ Include a copy of "Exhibit of Premiums and Losses (Statutory Page 14 Data)" with your submission ⇐⇐