

# Insurer's Reconciliation Statement

Calendar Year: 2017

DUE: March 15, 2018

Insurer Name: \_\_\_\_\_ NAIC Company Code: \_\_\_\_\_

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

## 1. Direct Premiums Written

Enter the amount of direct premiums written during the period January 1, 2017 through December 31, 2017

This amount should equal what is reported to the Vermont Department of Financial Regulation 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, 2017 to June 7, 2017 is 1.45%  
The assessment rate from June 8, 2017 to December 31, 2017 is 1.4%

Multiply the amount on line 1 that was written between January 1, 2017 and June 7, 2017 by .0145  
Multiply the amount on line 1 that was written between June 8, 2017 and December 31, 2017 by .014

The total annual assessment due is: 2. \_\_\_\_\_

## 3. Quarterly Assessments Previously Submitted

Enter the quarterly assessments due by quarter throughout calendar year 2017.

Amount carried forward from 2016

1 <sup>st</sup> Quarter	_____	January 1, 2017 – March 31, 2017
2 <sup>nd</sup> Quarter	_____	April 1, 2017 – June 30, 2017
3 <sup>rd</sup> Quarter	_____	July 1, 2017 – September 30, 2017
4 <sup>th</sup> Quarter	_____	October 1, 2017 – December 31, 2017

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

## 4. Credit to be applied to next quarterly submission or amount to be refunded

If line 3 is less than zero, this amount will carry forward and be credited toward the next quarterly assessment due.

**CREDIT** 4. \_\_\_\_\_

## 5. 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 PAID** 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 ⇐⇐