Vermont Department of Labor | Workers' Compensation Assessment Fund

Insurer's Reconciliation Statement

Calendar Year: 2010 DUE: March 15, 2011

Group Name: _____ NAIC Group Code: _____

Company Name: _____ NAIC Company Code: _____

Did the company name change during calendar year 2010? ☐Yes ☐No **New Company Name:** _____
Did the group number change? ☐Yes ☐No **New Group Number:** _____
During calendar year 2010 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, 2010 through December 31, 2010

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 form January 1, 2010 to June 30, 2010 is .96%
The assessment rate from July 1, 2010 to December 31, 2010 is 1.425%
Multiply the amount on line 1 that was written between January 1, 2010 and June 30, 2010 by .0096. _____
Multiply the amount on line 1 that was written between July 1, 2010 and December 31, 2010 by .01425. _____
This is the total annual assessment due. **2.** _____

3. Quarterly Assessments Previously Submitted

Enter the quarterly assessments due by quarter throughout calendar year 2010.

Amount carried forward from 2009	_____	
1st Quarter	_____	January 1, 2010 – March 31, 2010
2nd Quarter	_____	April 1, 2010 – June 30, 2010
3rd Quarter	_____	July 1, 2010 – September 30, 2010
4th Quarter	_____	October 1, 2010 – December 31, 2010

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 ⇦⇦