VERMONT
VERMONT DEPARTMENT OF LABOR

5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488

SELF-INSURER'S REPORT

DUE MARCH 1st

Calendar Year: _____

Company: _____

1. Total Workers' Compensation Benefits paid for the reporting period: _____

   (a) Indemnity: $ _____

   (b) Medical: $ _____

   (c) Other: $ _____

   (d) Total: $ _____

2. Assessment due [line (d) x .01]: $ _____

3. Claims for which benefits were paid for this reporting period. (this may be included on a separate form provided that all the information requested is present):

Name	Date of Injury	State File Number	Indemnity	Medical	Other	Total

4. Certification:

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

_____ _____
Signature Date

Name: _____ Telephone: _____

Title: _____ Email: _____

Group Address: _____ Company Address: _____

_____ _____

_____ _____