DOL **FORM 13-A** (Rev. 8/16)

Reporter's Fed. Id No. _____
Fiscal Year _____

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

AGGREGATE Annual Reporting Form – Reporting Period 7/01 – 6/30

Carrier:☐ NAIC#_____

Third Party Administrator:☐ for Carrier: _____

Self-Insured:☐

NAME: _____
ADDRESS: _____
CONTACT PERSON: _____
CONTACT PHONE NUMBER: _____ E-MAIL: _____

	Benefit or Expense Paid Out	**Total # Claims in which Benefit/Expense was Paid**	**Total Amount Paid (all claims)**	**Average benefit/cost per claim**
1	Temporary Total Disability - Form 32		$	$
2	Temporary Partial Disability – Form 32		$	$
3	Permanent Partial Impairment – Form 22		$	$
4	Permanent Total Impairment – Form 22		$	$
5	Medical		$	$
6	Vocational Rehabilitation		$	$
7	Fatality (Spouse/dependent) – Form 23		$	$
8	Funeral		$	$
9	Lump Sum Payments (Form 22 or 16) *		$	$
10	Legal Expenses (Defense)		$	$
11	**TOTAL All Benefits/Expenses Paid**		$	$

		Total Number
12	First Reports of Injury, Form 1	
13	Fatalities	
14	Medical Only Claims	

15	Attach a list of all employers this report reflects.

INSTRUCTIONS:

1. COMPLETE each blank. Use N/A if appropriate.
2. Provide information for FISCAL YEAR (7/1 – 6/30) ONLY.
3. Do NOT duplicate report. If TPA is used, employer/carrier/TPA should agree upon annual reporter.
4. *Attach itemization of lump sums of Form 16 and 22 if known.