VERMONT

Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488

DOL Form 16 (Rev. 9/11)
Replaces Former Form 14 and Form 15
State File #: _____
Ins. Co.. File # _____
Date of Injury _____

SETTLEMENT AGREEMENT
Attach any additional conditions, terms, etc.

The injured worker _____ whose address is:

_____ ,

and **insurance carrier **employer _____ agrees that a work injury occurred on _____ ,20 _____ while worker was employed by _____ causing the following injury: _____

and resulting in: ☐temporary total disability ☐ temporary partial disability ☐ permanent partial disability

☐permanent total disability ☐medical only

Beginning on: _____ ,20 _____

That the employee's average weekly wage before the accident was $ _____
(insurer must have filed a wage statement)

This is an agreement in which the claimant agrees to accept $ _____ , in full and final settlement of :

(list benefits being closed out – indemnity, medical, VR, etc.)
sustained as a result of the accident referred to above.

☐ It is agreed that the carrier will continue to furnish:
All reasonable past, present and future medical, hospital, surgical and nursing services and supplies necessary for the treatment of this injury.
Other (describe): _____

If payment is to be in a lump sum please complete one of the paragraphs below:

_____ Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of $ _____ . This lump sum is compensation for permanent impairment that will affect the claimant for the rest of his/her life. The claimant's remaining life expectancy is _____ years or _____ months. Therefore, even though paid in a lump sum, claimant's benefit (after deduction of attorney fees of _____ and expenses of _____) shall be considered to be $ _____ per month beginning on the date of approval of this settlement

OR

_____ Claimant agrees to accept and the employer/carrier agrees to pay a lump sum of $ _____ . Claimant expressly requests that the lump sum not be prorated as otherwise required by 21 VSA §652(c).

APPROVAL AND REVIEW

This settlement shall not be binding or operative until it is approved by the Commissioner of Labor or designee

Dated at _____ this _____ day of _____ ,20 _____

_____
Insurance Carrier or Employer

_____ By _____
Employee

_____
Official Title

APPROVED: _____ ,20 ___ _____
Commissioner of Labor/Designee