AmTrust North America
An AmTrust Financial Company

Vermont
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

Table of Contents

AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?

- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.

We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.

Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

MKT6310 06/23

AmTrust North America
An AmTrust Financial Company

EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
An AmTrust Financial Company

Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 1 (Rev. 9/11)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYER FIRST REPORT OF INJURY

Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee Social Security Number MUST be provided.

EMPLOYER

1. Legal Name:	2. Business Name:	
3. Mail Address: No. and Street	City	State Zip
4. Location (if different from Mail Address):	5. Telephone Number, Extension and Contact Person.:	
6. Nature of Business (list principal products or service of concern):	7. Do you regularly employ 10 or more employees? ☐ Yes ☐ No	8. Federal ID No.:

EMPLOYEE

9. Name: First Name	Middle Initial	Last Name	10. Social Security No.:	11. Date of Birth:	
12. Home Address: No. and Street		13. Home Phone No.:	14. Work Phone No:	15. Age:	
City	State	Zip	16. Job Title:	17. Sex: ☐ M ☐ F	
18. Wages $ Per	Hours Per Day Days Per Week	19. If board, lodging, etc. were furnished in addition to wages, state estimated value: $	20. Was employee hired in VT? ☐ Yes ☐ No	21. Date of Hire	

ACCIDENT

22. Date of Accident:	Accident Time: AM PM	Began Shift: AM PM	23. Location of Accident: Town or City	State
24. Machine, tool, object, motor vehicle or substance directly causing injury:				
25. On employer's premises? ☐ Yes ☐ No	If yes, name of department:			
26. Describe what employee was doing:	Was this the employee's regular occupation? ☐ Yes ☐ No			
27. How did accident occur? Describe events leading up to the accident:				

INJURY

28. Describe the injury and the part of the body injured.				**29. Was this a first-aid only injury:** ☐ Yes ☐ No	
30. Any Lost Time? ☐ Yes ☐ No	If yes, date disability began	Last date paid in full:	31. Employee returned to work? ☐ Yes ☐ No	If yes, date	Medical Only Incident: Yes ☐ No ☐
32. Did injury result in death? ☐ Yes ☐ No	If yes, date of death.				
33. Name and address of Physician:					
34. Name and address of Hospital:			Remained Overnight ☐ Yes ☐	No	

INS

35. Insurance Company Named on Workers' Compensation Policy Name in full: _____ Policy No.	35A. Claim Administrator Company Name AMTRUST NORTH AMERICA Phone Number 888-239-3909
Signed by: _____ Employer or Representative Title Date	

Equal Opportunity is the Law

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

VERMONT
DEPARTMENT OF LABOR

Employer's Liability and Workers' Compensation

NOTICE TO EMPLOYEES

This employer, _____ , has complied with the provisions of Title 21 of the Vermont Statutes, Annotated §687, by obtaining Workers' Compensation Insurance coverage through:

AmTrust North America

(Insurance Carrier)

Workers' Compensation benefits for lost time, medical expenses, disability or death because of a work-related injury are available through the above named company.

- **An injured employee MUST immediately notify his/her employer of an injury.**
- **The employer MUST file an Employee Claim and Employer's First Report of Injury (Form 1) with the Vermont Department of Labor within 72 hours of the notice of an injury that requires medical attention or results in time lost from work. The employer must also provide a copy of the Form 1 to the injured worker and to the insurance carrier.**
- **If the employer fails to file a First Report, an employee may file a Notice of Injury and Claim for Compensation (Form 5) with the Vermont Department of Labor within six months of the date of injury.**
- **Information concerning injured worker rights and benefits is available on the department's Workers' Compensation website at http://www.labor.vermont.gov or by calling (802) 828-2286.**

Equal Opportunity is the Law
The State of Vermont is an Equal Opportunity/Affirmative Action Employer. Applications from women, individuals with disabilities, and people from diverse cultural backgrounds are encouraged. Auxiliary aids and services are available upon request to individuals with disabilities. 711 (TTY/Relay Service) or 802-828-4203 TDD (Vermont Department of Labor).

ESTADO DE VERMONT

Responsabilidades de la Empresa Contratante & Indemnización por Accidentes Laborales (*Workers' Compensation*)

NOTIFICACIÓN A LOS EMPLEADOS

ESTA EMPRESA CONTRATANTE, _____,
HA CUMPLIDO CON LAS DISPOSICIONES DEL TÍTULO 21 DE LOS ESTATUTOS DEL ESTADO DE VERMONT, ANOTADAS EN LA § 687, ASEGURÁNDOSE BAJO UNA PÓLIZA DE SEGURO CONTRA ACCIDENTES LABORALES EMITIDA POR:

(COMPAÑÍA DE SEGUROS)

EL EMPLEADO DE ESTA COMPAÑÍA TIENE DERECHO A SER INDEMNIZADO POR EL TIEMPO PERDIDO, GASTOS MÉDICO GENERADOS, INCAPACIDAD SUFRIDA O LA MUERTE, SI ÉSTOS FUESEN ATRIBUIBLES A UNA LESIÓN RELACIONADA CON SU TRABAJO.

- **LA LESIÓN SUFRIDA TENDRÁ QUE SER REPORTADA INMEDIATAMENTE A LA COMPAÑÍA CONTRATANTE POR EL EMPLEADO LESIONADO.**

- **LA EMPRESA CONTRATANTE TENDRÁ QUE REMITIR UNA RECLAMACIÓN A NOMBRE DEL EMPLEADO Y PRESENTAR EL PRIMER REPORTE DE UNA LESIÓN EN EL FORMULARIO CORRESPONDIENTE (FORMULARIO 1) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES (*THE DEPARTMENT OF LABOR AND INDUSTRY*), POR CONCEPTO DE CUALQUIER LESIÓN QUE REQUIERA ATENCIÓN MÉDICA O QUE RESULTARA EN LA PÉRDIDA DE TIEMPO LABORAL. LA EMPRESA TENDRÁ QUE REMITIR DICHA RECLAMACIÓN Y REPORTE DENTRO DE 72 HORAS DESPUÉS DE HABER RECIBIDO NOTIFICACIÓN DE LA LESIÓN. LA EMPRESA CONTRATANTE TAMBIÉN LE TENDRÁ QUE PROPORCIONAR UNA COPIA DEL FINALIZADO FORMULARIO 1 AL EMPLEADO LESIONADO Y A LA COMPAÑÍA DE SEGUROS.**

- **SI LA EMPRESA CONTRATANTE NO CUMPLIERA CON LA PRESENTACIÓN DEL PRECITADO PRIMER REPORTE, EL EMPLEADO PODRÁ LLENAR Y REMITIR EL FORMULARIO 5 TITULADO *NOTIFICACIÓN DE LESIÓN Y RECLAMACIÓN PARA INDEMNIZACIÓN* (*NOTICE OF INJURY AND CLAIM FOR COMPENSATION—FORM 5*) ANTE EL MINISTERIO DE ASUNTOS LABORALES E INDUSTRIALES DENTRO DE SEIS MESES, CONTADOS A PARTIR DE LA FECHA DE LA LESIÓN.**

- **SI DESEA INFORMACIÓN REFERENTE A LOS DERECHOS Y BENEFICIOS DEL EMPLEADO LESIONADO VISITE EL *WEB SITE* DE SEGURO CONTRA ACCIDENTES LABORALES http://www.state.vt.us/labind/wcindex.htm O SÍRVASE LLAMAR AL (802) 828-2286**

FORMULARIO 31 2/03

NOTICE

This is a translation of a document originally drawn up in English. Accordingly, it is understood that all legal rights, responsibilities and/or obligations are governed by the original English version of this document.

ADVERTENCIA

Ésta es la traducción de un documento originalmente redactado en inglés. Consiguientemente, hágase saber que todos los derechos legales, responsabilidades y/u obligaciones expresadas en el mismo se regirán por la versión original del documento redactada en inglés.

State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488

State File No. _____

EMPLOYEE'S NOTICE OF INJURY AND CLAIM FOR COMPENSATION

Employee:

Name: _____
Street: _____
City: _____
State: _____ Zip: _____
DOB: _____
Social Security No.: _____
Home Telephone Number: _____
Work Telephone Number: _____
Email Address: _____

Employer:

Legal Name: _____
D/B/A: _____
Street: _____
City: _____
State: _____ Zip: _____
Owner/Supervisor Name: _____
Telephone Number: _____

Injury:

Date of Injury: _____
Job Site Location: _____
Body Part Injured: _____
Machine or Tool Involved: _____
Did you notify your employer/supervisor at the time of the injury/illness? ☐ No ☐ Yes – Date: _____
Briefly explain how injury/illness occurred:

_____

EMPLOYEE SEEKS COMPENSATION FOR:
Lost Time Benefits: _____ Medical Benefits: _____ Both: _____
If you lost time from work, indicate period of lost time From: _____ To: _____
Dependency Benefits:

Name of Dependent	Date of Birth	Relationship

In all cases to facilitate the processing of this claim please attach all supporting medical documentation.

_____ _____
Employee Signature Date Signed Attorney Signature (if represented) Date Signed

Employee's Notice of Injury and Claim For Compensation (Form 5)

INSTRUCTION SHEET

In workers' compensation claims the **injured worker has the burden of proving that his or her injuries are work related.** The injured worker must demonstrate through medical evidence the extent of the injuries and disability as well as the causal relationship to the work injury. In order to process your claim for workers' compensation benefits **you MUST provide the following information:**

1. Complete the attached Employee's Notice of Injury and Claim For Compensation (Form 5). If you are claiming lost time from work, please also complete the attached Certificate of Dependency and Employee Exemption Report (Form 10/10s).

2. Enclose copies of relevant medical records. This is required to process your claim. Check off and attach any of the relevant medical records noted below:

___ treatment notes from each office visit you had with any medical provider
___ emergency room records
___ radiology reports (not films)
___ chiropractic records
___ physical therapy notes
___ written clarification from your treating providers as to whether they feel your condition is work-related (strongly recommended).

3. List names of any witnesses to your injury or persons involved in your accident. If possible, include contact information and attach written statement which are signed and dated.
_____

4. Answer the following questions (attach additional sheets if necessary)
What are your present symptoms? _____
Where did you first receive treatment? _____on what date?_____
Who chose the first treating medical provider? ____ you ___ employer
Who is currently providing treatment to you? _____
When is your next appointment date? _____ with whom?_____
Have you returned to work? ___yes ___ no - if yes, on what date? _____
Are you working your regular hours? ___yes ___no - if no, hours working _____

Return this instruction sheet with the Form 5 and Form 10 to the Dept. address above.

It is recommended that you keep copies of all submitted information for your records. If you are still receiving treatment for your injury/illness you should continue to provide updated medical records to the insurance company and this office until a decision is made on your claim.

Department of Labor
Workers' Compensation Division
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286; TDD 800-650-4152

DOL FORM 2 Rev. 5/2024

State File No. _____
Date of Injury _____
Ins. Co. File No. _____

Denial of Workers' Compensation Benefits by Employer or Carrier

THIS FORM IS FILED BY YOUR EMPLOYER'S WORKERS' COMPENSATION INSURANCE COMPANY. They have filed this denial in accordance with Vermont Workers' Compensation Rule 3.2200. Notice must be sent to the injured worker and the Department of Labor. **Supporting evidence must be attached.**

TO:
Claimant's Name: _____

Address: _____ Telephone No.: _____

Employer: _____ Date of Injury: _____

Date Notice of Injury Received by Employer: _____

Body part injured/injuries accepted by carrier: _____

☐ Entire Claim Denied ☐ Indemnity Benefits Denied ☐ Medical Benefits Denied

Check off only the reasons below that apply and give a brief statement of the specific facts you are relying on to support the denial.

☐ **DOCUMENTS ATTACHED**

A. ☐ Medical bill not related to accepted injury (please specify date of bill). _____

B. ☐ No injury arising out of and in the course of employment. _____

C. ☐ No indemnity due. _____

D. ☐ No causal relationship between injury and disability. _____

E. ☐ Medical release (Form 7) not returned by claimant. _____

F. ☐ Treatment is not reasonable, necessary or related to the injury _____

G. ☐ Preauthorization of medical treatment _____

H. ☐ Other (Specify): _____

Issued By:
Carrier: _____ Administrator (if not carrier): _____

Adjuster Name: _____ Telephone No.: _____

Adjuster Signature: _____ Employer: _____

Date Notice Sent to Claimant: _____

NOTICE and FORM for EMPLOYEE to APPEAL DENIAL

TO APPEAL, COMPLETE THE INFORMATION BELOW **AND** ATTACH EVIDENCE (for example, doctor's notes, emergency room records, any other medical records such as physical therapy, radiology reports, etc. or witness statements) TO SUPPORT THAT YOUR INJURY AROSE OUT OF YOUR WORK. KEEP A COPY OF THIS FORM FOR YOUR RECORDS AND MAIL A COPY OF IT TO BOTH the Department of Labor at the address above and the insurance carrier.

Did you notify your employer/supervisor of the injury/illness? Yes _____ No _____
Identify who you reported the injury to and on what date. _____
Briefly explain how the injury/illness occurred (attach additional pages if necessary):

_____

Did you lose time from work because of the injury? Yes _____ No _____
If yes, on what date did you begin losing time from work? _____
If you have returned to work, indicate the date on which you returned. _____

Please check off and attach documents that you are relying on for your appeal:

- ☐ treatment notes from each office visit you had with any medical provider
- ☐ emergency room records
- ☐ radiology reports (not films)
- ☐ chiropractic records
- ☐ physical therapy notes
- ☐ written clarification from your treating providers as to whether they feel your condition is work-related (strongly recommended).

I am seeking all workers' compensation benefits allowed by law.

_____
Employee Signature Date Signed

_____
Employee Printed Name

_____ _____
Employee Current Mailing Address Employee Personal E-mail Address

_____ _____
Employee Current City, State, Zip Employee Contact Phone Number

If you have further questions please call or office at (802) 828-2286 or check our website at www.labor.vermont.gov

VERMONT

Department of Labor, Workers' Workers' Compensation
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286; TDD 800-650-4152
www.labor.vermont.gov

DOL FORM 25 (Rev. 1/2018)

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____

WAGE STATEMENT – For injuries occurring on or after July 1, 2008

Employee: _____

Employer: _____

Wage Rate: $ _____ per _____ Number of Days Hired to Work: _____ Number of Hours Hired to Work: _____

	Week Ending			Number of Hours or Days Worked	Gross Wages	Extras (as in 6 or 7) Please indicate what the extra is, for example, $1000.00 bonus
	Month	Day	Year			
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						

INSTRUCTIONS:
Read Carefully

1. Enter **GROSS** wages of employee for 26 weeks before date of accident (**NOT take-home pay**).
2. Do not include the week of the accident.
3. Leave blank those weeks in which the employee had excused absences for which he/she was paid for less than ½ of a work week.
4. Leave blank those weeks in which you had reduced operations or a plant shutdown and for which the employee was paid for less than ½ of a work week.
5. Do not enter those weeks in which an employee was on vacation for more than ½ of a work week.
6. If room, board, lodging or other "extras" (electricity, fuel, etc.) are provided in addition to monetary wages, break these down into a weekly value, and include and describe the income in the column marked "EXTRAS." This includes tips if not included in gross wages.
7. Include any bonuses and commissions paid to the employee in addition to wages in the column marked "EXTRAS."
8. Enter the dates when your normal work week ends (not the date a check is issued to the employee) and the number of hours or days worked.

When did the employee begin losing time? _____ Was the employee paid in full for the day of the accident? _____

Are employee's wages subject to any child support withholding order? ☐Yes ☐No
If yes, in what amount? $ _____ per _____

Day of the week the check will be mailed to the claimant or deposited in the claimant's account _____

This is a correct statement of the employee's earnings as taken from the employer's payroll records.

By: _____ Position Title: _____
Signature of Preparer

Print Name: _____ Date: _____