



## **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:

**BERKLEY INDUSTRIAL COMP**

(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).

## **VERMONT WORK INJURY REPORTING PROCEDURES**

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

### **Employer First Report of Injury (Form 1)**

This form must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to us. As an alternative, Employer First Reports of Injury (FROI's) may be submitted to us online at: [www.berkindcomp.com](http://www.berkindcomp.com). Online Reporting Instructions are enclosed. Maintain a copy of the FROI for your records. Keep a separate file for each workers' compensation claim.

### **Supervisor's Report**

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the FROI. If the FROI is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

### **Wage Statement (DOL Form 25)**

The Wage Statement must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Wage Statement.

**Do not delay reporting the Employer First Report of Injury for completion of the Wage Statement.**

### **Work Status**

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		21. Date of Hire	
ACCIDENT	22. Date of Accident:		Accident Time AM PM		Began Shift: AM PM		23. Location of Accident: Town or State City	
	24. Machine, tool, object, motor vehicle or substance directly causing injury:							
	25. On employer’s premises? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, name of department:			
	26. Describe what employee was doing:				Was this the employee’s regular occupation? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	30. Any Lost Time? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date disability began		Last date paid in full:		31. Employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	32. Did injury result in death? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of death.					
	33. Name and address of Physician:							
34. Name and address of Hospital:						Remained Overnight <input type="checkbox"/> Yes <input type="checkbox"/> No		
INS	35. Insurance Company Named on Workers’ Compensation Policy				35A. Claim Administrator			
	Name in full: _____				Company Name _____			
	Policy No. _____				Phone Number _____			
Signed by: _____								
Employer or Representative				Title		Date		



Department of Labor, Workers' Compensation  
 Workers' Compensation  
 PO Box 488  
 Montpelier, VT 05601-0488  
 (802) 828-2286; TDD 800-650-4152  
[www.labor.vermont.gov](http://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 1/2 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 1/2 of a work week.
5. Do not enter those weeks in which an employee was on vacation for more than 1/2 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: \_\_\_\_\_