



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

DOL Form 15 (Rev. 2/11)
 State File # _____
 Ins. Co. File # _____
 Date of Injury _____
 Fed ID No. _____

SETTLEMENT AGREEMENT

It is hereby agreed by and between _____ the injured worker, whose address is _____, and _____

****insurance carrier** ****employer,** that worker claims a work injury on _____, 20 _____ by the said worker while in the employ of _____ whose address is _____ causing the following injury: _____ and resulting in temporary total disability which began _____, 20 _____.

That the employee's average weekly wage before the accident was \$ _____

This is an agreement in which the claimant agrees to accept \$ _____, in full and final settlement of all claims for: (describe injury) _____ sustained as a result of the accident referred to above, including ****his **her** claim for past, present and future compensation for temporary total disability, temporary partial disability, permanent partial disability or permanent total disability, dependency benefits, medical, hospital, surgical and nursing expenses, and vocational rehabilitation benefits.

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 agreement or any settlement thereunder shall not be binding or operative unless and until this settlement agreement is approved by the Commissioner of Labor.

Dated at _____ this _____ day of _____, 20 _____

APPROVED: _____, 20 _____

 Insurance Carrier or Employer

 Commissioner of Labor/Designee By _____

 Official Title

 Employee

 Witness

****Strike out inappropriate expressions**