



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

DOL Form 21  
 State File No.: \_\_\_\_\_  
 Ins. Co. File No.: \_\_\_\_\_  
 Date of Injury: \_\_\_\_\_

Rev 6/10

**Agreement for Temporary Total Disability Compensation**

IT IS AGREED, between \_\_\_\_\_, the employee, whose present mailing address is:

\_\_\_\_\_  
*Street, Rural Route, Box Number, City, State, Zip*

AND \_\_\_\_\_, the insurance carrier/employer that on \_\_\_\_\_ the employee suffered an accident while in the employ of \_\_\_\_\_ of the city/town of \_\_\_\_\_ state of \_\_\_\_\_ causing the following injury: \_\_\_\_\_ and resulting in temporary total disability beginning on: \_\_\_\_\_

**WEEKLY COMPENSATION RATE**

The employee is entitled to a weekly compensation rate of two-thirds (66.667%) of his/her average weekly wage not to exceed his/her weekly net income. S/he is further entitled to an additional \$10.00 per week for each dependent child under 21 years of age provided that the total weekly compensation not exceed the employee's weekly net income.

A.	Claimant's Average Weekly Wage	A.	\$	_____
B.	Weekly Compensation Rate (66.667% of A.W.W.; Weekly Net Income; Minimum or Maximum Rate)	B.	\$	_____
C.	Number of Dependents multiplied by \$10.00	C.	\$	_____
D.	Total Weekly Compensation Rate	D.	\$	_____

**DISABILITY**

Beginning on the fourth day of disability, the \_\_\_\_\_ day of \_\_\_\_\_ and continuing during the period of total disability, the employee shall receive compensation at said rate.

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

**EMPLOYEE OBLIGATION TO REPORT WORK AND EARNINGS**

Temporary Total Disability compensation is provided only where an injury causes total disability from any work. By signing this agreement the employee is stating that he or she is not currently working, and that he or she is obligated to report promptly any work earnings, wages or benefits to the insurance carrier/employer and the department.

\_\_\_\_\_  
 Insurance Adjuster Name (Print)

\_\_\_\_\_  
 Employee Name (Print)

\_\_\_\_\_  
 Insurance Adjuster Signature      Date

\_\_\_\_\_  
 Employee Signature      Date

APPROVED: \_\_\_\_\_  
 Date

\_\_\_\_\_  
 Commissioner of Labor/Designee