



CASE FILE NO. _____

CARRIER FILE NO. _____

STATE OF DELAWARE
OFFICE OF WORKERS' COMPENSATION
AGREEMENT AS TO COMPENSATION

Employee _____ Employer _____

Address _____ Address _____

Insurance Carrier/Self-insurer _____ Third party adjuster _____

Address _____ Address _____

The above have reached an agreement in regard to compensation for the injury sustained by said employee and submit the following statement of facts relative thereto:

Date of Injury _____ Date Disability Began _____

Cause/Place of Accident _____

Nature/Part of Body _____

Probable Length of Disability (if known) _____

The terms of this agreement under the above facts are as follows:

This agreement is for (check all that apply) _____ Total Disability _____ Temporary Partial Disability _____
_____ Permanent Partial Disability _____ Disfigurement _____ Commutation _____ Medical Only _____
_____ Salary in Lieu of Workers' Compensation

That the said _____ shall receive compensation at the rate of \$ _____ per week based upon an average weekly wage of \$ _____ and that said compensation shall be payable _____ weekly _____ bi-weekly _____ monthly _____ other (specify) from and including the _____ day of _____ month _____ year until terminated in accordance with the provisions of the Workers' Compensation

Law of the State of Delaware.

See reverse side

BENEFITS FOR TOTAL/PARTIAL DISABILITY, (LOST WAGES) SHALL REQUIRE YOU TO ADVISE THE NAMED

CARRIER/SELF-INSURER/THIRD PARTY ADJUSTER OF ANY CHANGES IN EMPLOYMENT STATUS AND/OR DISABILITY. FAILURE TO NOTIFY A CHANGE IN STATUS IS PUNISHABLE PURSUANT TO TITLE 18, DELAWARE CODE, CHAPTER 24, AND/OR TITLE II, DELAWARE CODE, SECTION 913.

Witness _____
(signature)

Employee _____
(signature)

Address _____

Adjuster/Attorney _____
(signature)

Phone number _____

Date of agreement _____

For Accounting Use Only:

Approved by _____

Date of Approval _____