STATE OF DELAWARE **Case File No**

WORKERS COMPENSATION FUND

ELIGIBILITY CERTIFICATION FORM

The Office of Workers Compensation has received a petition for a hearing before the Industrial Accident Board with regard to an injury that you sustained. The purpose of the petition is to request the Board to order the termination of the disability benefits currently being paid to you. Having filed this petition, the company will cease paying your disability benefits until the case is heard by the Board or otherwise settled between the parties. The Office of Workers Compensation may be obliged to continue paying your present disability benefits until the case is heard by the Board or settled. In order for your benefits to be reinstated, you must complete this form and return it to the Office of Workers Compensation immediately.

(Please Print)

Name_____

Address_____

_____

Phone number_____

Social Security Number_____

Employer (at the time of injury

Check one of the statements below regarding your employment status:

☐ **I have not been gainfully employed due to my industrial accident.**

☐ **I have been gainfully employed effective _____.**

Hours per week _____ Hourly rate_____ Average weekly gross wages_____

I affirm that the facts stated above are true and accurate to the best of my knowledge and belief. I also acknowledge my responsibility to notify the Office of Workers' Compensation immediately if I return to gainful employment, change my employment status, change my mailing address, or receive money from a third party action. I am aware that failure to notify the Office of Workers Compensation of a change in employment status while receiving Workers Compensation Fund checks may constitute fraud and result in criminal and/or civil prosecution.

_____

Claimant signature/date

Please return completed form to:

Office of Workers Compensation
Attn:Fiscal Unit
4425 N. Market Street, 3rd Fl
Wilmington, DE 19802
Telephone number: (302) 761-8200
Fax number: (302) 622-4103