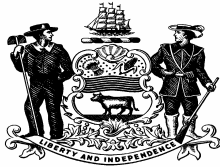

CASE FILE NO. ____________________

CARRIER FILE NO. __________________

STATE OF DELAWARE

OFFICE OF WORKERS' COMPENSATION

RECEIPT OF COMPENSATION PAID

DATE ______________________

Received of ____
(Insurance Carrier/Self-Insurer/Third Party Adjuster)

the sum of $ ____________________, making in all the total sum of $ ___________________

in settlement of compensation due for the ________________________________ disability of
(type)

____ which began
(employee name)

on ___________________________________, and terminated on _____________________.
(date) (date)

____
Employee Signature

____
Address

____

Your signature on this receipt will terminate your rights to receive the worker's compensation benefits specified above on the date indicated. This form is not a release of the employer's or the insurance carrier's workers' compensation liability. It is merely a receipt of compensation paid. The claimant has the right within five years after the date of the last payment to petition the Office of Workers' Compensation for additional benefits.

Document No. 60-07-01-02-12/97