OWC CASE FILE NO. _____

CARRIER FILE NO. _____

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

Employee: _____ Employer: _____

Address: _____ Address: _____

_____ _____

_____ _____

Insurance Carrier/Self-Insurer: _____ Third party adjuster: _____

Address: _____ Address: _____

_____ _____

_____ _____

The above have reached and 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: _____

_____

Length of Disability (if known): _____

Terms of this agreement under the above facts are as follows:

This agreement is for 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 ncluding the

_____

Day of _____ month _____ year until terminated in accordance with provisions of Workers' Compensation Law of the State of Delaware

see reverse side

_____
Claimant Initials

BENEFITS FOR TOTAL/PARTIAL DISABILITY, (LOST WAGES) SHALL REQUIRE YOU TO ADVISE THE NAMED CARRIER/SELF-INSURED/THIRD PARTY ADJUSTER OF ANY CHNGES 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 _____ Employee _____
(signature) (signature)

Address _____
_____

Adjuster/Attorney _____

Phone number _____

Date of agreement _____

PURSUANT TO 19 DEL. C. 2322E(d), THE "EMPLOYER'S MODIFIED DUTY AVAILABLITY REPORT" SHALL ACCOMPANY THIS AGREEMENT AND THE COMPLETED REPORT SHALL BE FORWARDED TO THE HEALTHCARE PROVIDER/PHYSICIAN MOST RESPONSIBLE FOR TREATMENT WITHING 14 DAYS. THE INSURANCE CARRIER FOR AND INSURED EMPLOYER SHALL BE INDEPENDENTLY RESPONSIBLE FOR PROVIDING A COMPLETED REPORT OF MODIFIED-DUTY JOBS TO THE PROVIDER/PHYSICIAN.

For Accounting Use Only by Delaware OWC

Approved by _____

Date of Approval _____

Revised 4/18/2023