CASE FILE NO.: _____
CARRIER NO.:_____

STATE OF DELAWARE
OFFICE OF WORKER'S COMPENSATION
AGREEMENT AS TO COMPENSATION

Employee _____ Employer _____
Address _____ Address _____
_____ _____
_____ _____
Insurance Carrier_____ 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 Worker's 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 (lump sum) 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.

BENEFITS FOR TOTAL/PARTIAL DISABILITY, (LOST WAGES) SHALL REQUIRE YOU TO ADVISE THE NAMED CARRIER/SELF-INSURER-THIRD PARTY ADJUSTER OF ANY CHANGE 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 11, DELAWARE CODE, SECTION 913.

Witness _____ Employee _____
(signature) (signature)
Address _____
_____
Adjuster/Attorney _____
Telephone number:_____
Date of agreement _____

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

For Accounting Use Only:
Approved by _____
Date of Approval _____