I.A.B. No.: _____

Carrier No.: _____

STATE OF DELAWARE
INDUSTRIAL ACCIDENT BOARD
RECEIPT FOR COMPENSATION PAID

[TYPE DATE HERE]

Received of _____, on behalf of _____, the sum of $_____ making in all the total sum of $_____ paid in settlement of Compensation due for _____ of the Employee, _____, which began on the _____ day of _____, A.D. _____ and terminated on the _____ day of _____, A.D. _____.

_____

SIGNATURE

[TYPE NAME & ADDRESS HERE]

Your signature on this receipt will terminate your rights to receive the workers' compensation benefits specified above on the date indicated. This form is not a release of the Employer's or Insurer's workers' compensation liability. It is merely a receipt for compensation paid. You may have the right within five years after the date of the last payment to petition the Industrial Accident Board for additional benefits. By signing this form you acknowledge your acceptance of the payment described above, that this constitutes your knowing representation under the law that you were legally entitled to such payment at all times and that any false representation is punishable under Federal and State laws.