I.A.B. No.: _____

Claim No.: _____

STATE OF DELAWARE
INDUSTRIAL ACCIDENT BOARD
AGREEMENT AS TO COMPENSATION

Employee: _____ Employer: _____

Address: _____ *Address:* _____

_____ _____

_____ _____

Insurer: _____ T.P.A.: _____

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 Accident: _____ Date Disability Began: _____

Cause of Accident: _____

_____

Nature of Injury: _____

_____

Disability Length: _____

_____

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 COMPENSATION: ☐

That the said _____ shall receive Compensation at the rate of $_____ per week based on an Average Weekly Wage of $_____ and that said Compensation shall be payable: WEEKLY: ☐; BI-WEEKLY: ☐; MONTHLY: ☐; LUMP SUM: ☐; OTHER (SPECIFY): _____ from and including the _____ day of _____, A.D. _____ until terminated in accordance with the provisions of the Workmen's Compensation Law of the State of Delaware.

EMPLOYEE: YOUR RECEIPT OF BENEFITS FOR TOTAL OR PARTIAL DISABILITY (LOST WAGES) SHALL REQUIRE YOU TO ADVISE THE NAMED INSURER / SELF-INSURER / THIRD PARTY ADJUSTOR AND EMPLOYER OF ANY CHANGE IN EMPLOYMENT STATUS AND / OR DISABILITY. YOUR FAILURE TO NOTIFY OF A CHANGE IN STATUS (E.G. YOUR CONTINUED ACCEPTANCE OF LOST WAGES AFTER RETURNING TO WORK CONTRARY TO YOUR REPRESENTATIONS) IS PUNISHABLE PURSUANT TO TITLE 18, DELAWARE CODE, CHAPTER 24, AS WELL AS TITLE 11, DELAWARE CODE, SECTION 913.

	(SEAL)
WITNESS SIGNATURE	EMPLOYEE SIGNATURE
(WITNESS ADDRESS ABOVE)	(EMPLOYEE ADDRESS ABOVE)
EMPLOYER AUTHORIZED AGENT (ADJUSTOR / ATTORNEY)	EMPLOYER SIGNATURE
TELEPHONE NUMBER	DATE OF AGREEMENT

EMPLOYER: PURSUANT TO 19 *DEL. C.* § 2322E(d) AN EMPLOYER'S MODIFIED DUTY AVAILABILITY REPORT SHALL ACCOMPANY THIS AGREEMENT AND THE COMPLETED REPORT SHALL BE FORWARDED TO THE PHYSICIAN MOST RESPONSIBLE FOR TREATMENT WITHIN FOURTEEN 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.

Applicable: ☐ *Inapplicable:* ☐

FOR OFFICIAL USE ONLY:

APPROVED BY

DATE OF APPROVAL

ANY PAYMENT OF MONEY ON YOUR CLAIM AND ANY FEELING OF COMPULSION BY YOUR EMPLOYER AND ITS INSURER TO ISSUE PAYMENT WAS MADE STRICTLY CONTINGENT UPON YOUR MATERIAL REPRESENTATIONS THAT YOU AND A WITNESS (WHERE APPLICABLE) WILL SIGN THIS AGREEMENT AND CORRESPONDING RECEIPT AS IS AND RETURN SAME IMMEDIATELY AND UNALTERED (BUT FOR YOUR SIGNATURES) TO YOUR EMPLOYER'S ATTORNEY. YOUR EMPLOYER ONLY FEELS BOUND BY THE TERMS OF THIS AGREEMENT, WHICH SHALL ONLY TAKE EFFECT ONCE SIGNED BY ITS AGENT. IF YOU DO NOT FULLY COMPLY WITH THESE TERMS THEN NO AGREEMENT EXISTS BETWEEN YOU AND YOUR EMPLOYER, YOUR EMPLOYER AND INSURER HAVE NO FEELING OF COMPULSION TO ACCEPT YOUR CLAIM OR ISSUE ANY PAYMENTS ON IT AND YOU ARE IMMEDIATELY TO RETURN ALL FUNDS DIRECTLY TO EMPLOYER'S ATTORNEY.