

I.A.B. No.: \_\_\_\_\_

Claim No.: \_\_\_\_\_



**STATE OF DELAWARE  
INDUSTRIAL ACCIDENT BOARD  
AGREEMENT AS TO COMPENSATION FOR DEATH**

(Memorandum of this Agreement must be filed with the Board)  
SECTION 107

We the undersigned, being all the dependents who are entitled to Compensation on account of the death of \_\_\_\_\_ from a personal injury sustained by him by an accident arising out of and in the course of his employment, and \_\_\_\_\_ in whose service the said \_\_\_\_\_ was employed at the time of said injury, have reached an Agreement in regard to the Compensation to be paid by said Employer:

Date of Accident: \_\_\_\_\_  
Place of Accident: \_\_\_\_\_  
Cause of Injury: \_\_\_\_\_  
Nature of Injury: \_\_\_\_\_  
Date of Death: \_\_\_\_\_

The terms of this Agreement under the above Facts are as follows:

That the Compensation payable shall be at the rate of \$\_\_\_\_\_ per week based upon an Average Weekly Wage of \$\_\_\_\_\_ at the time of said injury and shall be paid from the \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_, until terminated, to the following person or persons, or their legal representative, in accordance with the provisions of the Delaware Workmen's Compensation Law of 1917 as amended, and in the amount herein designated:

\_\_\_\_\_ : \$\_\_\_\_\_ per week.  
\_\_\_\_\_ : \$\_\_\_\_\_ per week.  
\_\_\_\_\_ : \$\_\_\_\_\_ per week.  
\_\_\_\_\_ : \$\_\_\_\_\_ per week.  
\_\_\_\_\_ : \$\_\_\_\_\_ per week.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, A.D. \_\_\_\_\_.

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DEPENDENT SIGNATURE

\_\_\_\_\_  
EMPLOYER SIGNATURE

\_\_\_\_\_  
DEPENDENT SIGNATURE

\_\_\_\_\_  
EMPLOYER'S AUTHORIZED AGENT

\_\_\_\_\_  
DEPENDENT SIGNATURE

\_\_\_\_\_  
APPROVED BY

\_\_\_\_\_  
DEPENDENT SIGNATURE

\_\_\_\_\_  
DATE OF APPROVAL

\_\_\_\_\_  
DEPENDENT SIGNATURE