DATE:

EMPLOYER: _____
CLAIMANT: _____
CLAIM NO.: _____
DATE OF LOSS: _____

OFFER TO ACCEPT CLAIM

On behalf of your Employer, please accept this as our OFFER to enter into an Agreement to accept your compensation claim. To accept our OFFER and bind us to this claim, you must strictly comply with the following three terms:

1. You and a witness (where applicable) must first sign and return directly to us the three Compensation Agreements enclosed with this letter so that we may sign and file them with the Industrial Accident Board as required by 19 *Del. C.* § 2344.

2. So long as we receive the executed Agreements back from you within ____ days of this letter, we shall accept your claim and immediately issue payments per 19 *Del. C.* § 2362.

3. This OFFER shall automatically expire without further notice if we do not receive these properly signed Agreements from you within ____ days of the date of this letter.

We have enclosed a GRATUITY of two weeks of compensation in case you need assistance during the time between your receipt of this OFFER and our receipt of the properly executed Agreements from you. This payment does not constitute our acceptance of your claim; as stated above, we will only accept your claim if you execute and return the Agreement we have enclosed within the next ____ days. Therefore, please remember:

> This claim is IN DISPUTE and payment is being made without prejudice to the Employer's right to dispute the compensability of the workers' compensation claim generally or the Employer's obligation to pay this bill in particular.

If we do not receive the properly executed Agreements from you within TWO WEEKS from the date of this letter, then we shall cease any gratuity and continue to have no feeling of compulsion to accept your claim or issue any payment unless you properly execute and return the enclosed Agreements to us within ____ days from the date of this letter.

Sincerely,

Claims Associate

THE STATUTE OF LIMITATIONS IS TWO YEARS FROM THE DATE OF ACCIDENT IN A CONTROVERTED CLAIM OR FIVE YEARS FROM THE DATE OF LAST PAYMENT FOR WHICH A RECEIPT HAS BEEN FILED.

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.