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