OWC FILE NO. _____

CARRIER FILE NO. _____

STATE OF DELAWARE

OFFICE OF WORKERS' COMPENSATION

RECEIPT OF COMPENSATION PAID

DATE _____

Received of _____
(Insurance Carrier/Self-Insurer/Third Party Adjuster)

the sum of $ _____, making in all the total sum of $ _____

in settlement of compensation due for the _____ of
(type)

_____ which began
(Employee Name)

on _____, and terminated on _____.
(date) (date)

_____
Employee Signature

_____
Address

_____

Your signature on this receipt will terminate your rights to receive the worker's compensation benefits specified above on the date indicated. This form is not a release of the employer's or the insurance carrier's workers' compensation liability. It is merely a receipt of compensation paid. The claimant has the right within five years after the date of the last payment to petition the Office of Workers' Compensation for additional benefits.

SUBMIT

Revised 1/18/2023