Date:

RE: **Claim No:**
Injured Worker:
Insured: **State of Delaware/**
Date of Injury:

Please complete the following and return, by fax at 1-800-432-9762 as soon as possible.

Employee's date of hire _____
Employee's first day out of work _____
Exact date employee returned to work _____
Anticipated date of return to work _____

Wages for 13 bi-weekly pay periods or 26 weeks prior to accident

	Bi-Weekly Period	Gross Wages		Bi-Weekly Period	Gross Wages
1			14		
2			15		
3			16		
4			17		
5			18		
6			19		
7			20		
8			21		
9			22		
10			23		
11			24		
12			25		
13			26		

_____ _____
Signature (Person Completing on behalf of the Agency) Date

Claims Representative: _____