22ND ANNUAL NORTH CAROLINA WORKERS' COMPENSATION EDUCATIONAL CONFERENCE

PRESENTERS:

ASIA PRINCE, DIRECTOR OF CLAIMS ADMINISTRATION

LUCY AUSTIN, SPECIAL DEPUTY COMMISSIONER

MEREDITH HENDERSON, EXECUTIVE SECRETARY

Learning Objectives

- Overview of common claims forms and best practices for filing
- Tips for Effective Form 24 and Form 23 Applications
- Guidelines for completion of other forms filed with the Executive Secretary's Office

Overview of Common Claims Forms and Best Practices for Filing

Filing Forms Claims Administration

- Effective February 1, 2017, all Forms and Motions filed with Claims Administration, MUST be filed via the Commission's Electronic Document Filing Portal ("EDFP"), pursuant to Rule 04 NCAC 10A .0108, except for the following:

DOCUMENT	QUALIFYING CONDITIONS	HOW TO FILE
Form 18	No IC file number has been assigned	Electronically to **forms@ic.nc.gov**; by mail, facsimile, or hand delivery
Form 18B	Always exempt from EDFP filing requirements	Electronically to **forms@ic.nc.gov**; by mail, facsimile, or hand delivery
Form 19	Always should be filed via EDI, except in claims involving non-insured employers or in claims for lung disease	Electronically via EDI, unless one of the exceptions applies, then electronically via **forms@ic.nc.gov**, by mail, facsimile, or hand delivery
Form 51	Always exempt from EDFP filing requirements	Electronically to **forms@ic.nc.gov**

Form 19 – First Report of Injury

North Carolina Industrial Commission

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

IC File #________
*Emp. Code #________
*Carrier Code #________
Employer FEIN________
Carrier File #________
*Required Information.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The use of this form is required under the provisions of the Workers' Compensation Act

Employee's Name | Employer's Name | ( ) - Telephone Number
Address | Employer's Address | City | State | Zip
City | State | Zip | Insurance Carrier | Policy Number
( ) - Home Telephone | ( ) - Work Telephone | Carrier's Address | City | State | Zip
- - Social Security Number | ☐ M ☐ F Sex | / / Date of Birth | ( ) - Carrier's Telephone Number | ( ) - Fax Number

Employer
1. Give nature of employer's business

Time And Place
2. Location of plant where injury occurred
County Department State if employer's premises
3. Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
5. Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
7. Date you or the supervisor first knew of injury / / 8. Name of supervisor

Person Injured
9. Occupation when injured
10. (a) Time employed by you (b) Wages per hour $
11. (a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week
(d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per

Cause And Nature Of Injury
12. Describe fully how injury occurred and what employee was doing when injured:
(Statement made without prejudice and without vouching for correctness of information)
13. List all injuries and specify body part involved (e.g. right hand or left hand):
14. Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
16. At what occupation 17. Employee's salary continued in full?
18. Was employee treated by a physician

Fatal Cases
19. Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name Date Completed / /
Signed by Official Title

OSHA 301 Information:
Case Number from Log: | Date Hired: / / | Time Employee began work on date of incident: : ☐ A.M. ☐ P.M. | If off-site medical treatment provided, answer entire next line.
Name of facility: | Address: Street/City/Zip/Telephone | ER visit? ☐ Yes ☐ No | Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

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FOR IC USE ONLY
RESEARCHER: ____
CC: ____
EC: ____
DATA ENTRY: ____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

- Common Problems
  - Incorrect Employer Name & Address
  - Expired Policies or Incorrect Policy Number
    - Updated policy information should be sent to the NC Rate Bureau.
  - Incorrect Carrier Address
  - Incorrect Employer FEIN
  - Incorrect Social Security Number
    - No Social Security number? Use the date of injury.
      - Example – Date of Injury – July 27, 2017 - 999 – 07 – 2717

Form 18 – Notice of Accident to Employer & Claim of Employee, Representative, or Dependent

North Carolina Industrial Commission

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

IC File #____________
Emp. Code #____________
Carrier Code #____________
Employer FEIN____________

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

Employee's Name | Employer's Name | Telephone Number
Address | Employer's Address | City | State | Zip
City | State | Zip | Insurance Carrier | Policy Number
Home Telephone | Work Telephone | Carrier's Address | City | State | Zip
Social Security Number | Sex ☐ M ☐ F | Date of Birth | Carrier's Telephone Number | Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: ________ (Time of Injury) on __/__/__ (Date (required)) at ________ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) ________
Describe how the injury or occupational disease occurred: ________

Occupation when injured: ________ Nature of employer's business: ________
Number of days out of work due to injury:
Medical treatment received? ☐Yes ☐No
Weekly wage: $ ________ Number of hours worked per day: ________ Days worked per week: ________

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent | Telephone Number
Address | City | State | Zip | Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY
RESEARCHER: ______
CC: ______
EC: ______
DATA ENTRY: ______

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FORM 18

MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

- Please be sure to include the plaintiff's social security number.
  - No Social Security number? Use the date of injury.
    - Example – Date of Injury – July 27, 2017
      - 999 – 07 – 2717
- Amending the Form 18? Please submit a cover letter informing the Commission of the changes made.
- It is the responsibility of the Carrier to forward the Form 18 acknowledgment letter to any third-party administrator on the claim.

Responding to the Form 18

- **Form 60** - Employer's Admission of Employee's Right to Compensation
- **Form 61** - Denial of Claim
- **Form 63** – Notice to Employee of Payment of Compensation Without Prejudice or Payment of Medical Benefits Only Without Prejudice
- **Note – Please do not submit a Form 21 to respond to a Form 18!**

Form 63

North Carolina Industrial Commission

NOTICE TO EMPLOYEE OF PAYMENT OF COMPENSATION WITHOUT PREJUDICE (G.S. §97-18(d)) OR PAYMENT OF MEDICAL BENEFITS ONLY WITHOUT PREJUDICE (G.S. §97-2(19) & §97-25)

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

IC File # ______
Emp. Code # ______
Carrier Code # ______
Carrier File # ______
Employer FEIN ______

Employee's Name | Employer's Name | ( ) - Telephone Number
Address | Employer's Address | City | State | Zip
City | State | Zip | Insurance Carrier | Policy Number
( ) - Home Telephone | ( ) - Work Telephone | Carrier's Address | City | State | Zip
- - Social Security Number | ☐ M ☐ F Sex | / / Date of Birth | ( ) - Carrier's Telephone Number | ( ) - Fax Number

TO EMPLOYEE (TO DEPENDENT(S) OR NEXT OF KIN IN CASES OF DEATH):

This is to inform you with regard to your claim for

☐ injury on __/__/__ (date) to __/__/__ (date) (Specify body part(s) involved):

☐ occupational disease as of __/__/__ to __/__/__ (date) (Specify condition(s) and body part(s) involved):

☐ death on __/__/__ (date)

TO EMPLOYER/CARRIER: FILL OUT ONLY THE APPLICABLE SECTION 1 OR 2 BELOW
NOTE: THE FOLLOWING ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT

SECTION 1: INDEMNITY BENEFITS

☐ Payments of workers' compensation benefits, both indemnity (money) and medical, will be made without prejudice to later deny your claim or Defendants' liability. Compensation may be continued during the investigation of your claim. The investigation may take up to 90 days, with a possible 30 day extension. During this period, Defendants may admit liability; contest your claim or Defendants' liability; or by Defendants' lack of action, waive the right to contest your claim.

The date on which Defendants first had written or actual notice of this claim was __/__/__ (date)

Disability began on __/__/__ (date) and the first payment of compensation is being mailed on __/__/__ (date)

Subject to verification, employee's average weekly wage was $_____, which results in a weekly compensation rate of $_____.

SECTION 2: MEDICAL BENEFITS ONLY (PAID WITHOUT PREJUDICE, NOT SUBJECT TO 90-DAY REQUIREMENT IN SECTION 1 ABOVE)

☐ Payment of medical compensation is expressly being made without prejudice to Defendants to later deny the compensability of your claim. In the event you miss more than 7 days of work, you must notify your employer or carrier because you may be entitled to additional benefits. Completion of this section (Section 2) does not constitute an agreement to pay indemnity (money) benefits to you under G.S. §97-18(d).

The date on which Defendants first had written or actual notice of this claim was __/__/__ (date).

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR | TITLE | / / DATE

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FORM 63

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

- Be sure to only select ONE box and not both when filing a Form 63

Failure to Respond to Form 18

- Carriers, employers and/or administrators must file a Form 60, 61, or 63 within 30 days of the Form 18 Acknowledgement letter date.
  - Failure to do so = $200 sanction

- To appeal sanctions, email sanctions@ic.nc.gov
  - Sanction will be lifted:
    - Form 60, 61, or 63 was timely filed.
    - Duplicate claim & Form 60, 61, or 63 filed in duplicate file.
    - Wrong carrier identified.
    - Plaintiff files for voluntary dismissal without prejudice.

Form 26A –Employer's Admission of Employee's Right to Permanent Partial Disability

- Common Problems
  - Cover letter with no contact information
  - No medical records
  - No job description
  - Missing signatures
  - No amputation chart
  - Line 4 "7 Day waiting period"
  - Line 8 "Date of First Payment" – Should be latter of MMI or return to work date
  - Overpayments – Form 28B required

Form 31 – Application of Lump Sum Award

N.C. Gen. Stat. § 97-44 – Lump Sums

"Whenever any weekly payment has been continued for not less than six weeks, the liability therefor may, in unusual cases, where the Industrial Commission deems it to be to the best interest of the employee or his dependents, or where it will prevent undue hardships on the employer or his insurance carrier, without prejudicing the interests of the employee or his dependents, be redeemed, in whole or in part, by the payment by the employer of a lump sum which shall be fixed by the Commission, but in no case to exceed the uncommuted value of the future installments which may be due under this Article. The Commission, however, in its discretion, may at any time in the case of a minor who has received permanently disabling injuries either partial or total provide that he be compensated, in whole or in part, by the payment of a lump sum, the amount of which shall be fixed by the Commission, but in no case to exceed the uncommuted value of the future installments which may be due under this Article."

Death Claims

- Forms and documentation that must be submitted where death results proximately from compensable injury or occupational disease – N.C. Gen. Stat. § 97-38
  - Form 30 – Agreement for Compensation for Death
  - Form 30D - Award Approving Agreement for Compensation for Death
  - Form 29 – Supplemental Report for Fatal Accidents
  - Form 42 – Application for Appointment of Guardian *ad Litem*
  - Death Certificate
  - Marriage Certificate
  - Divorce Decree
  - Birth Certificate

Death Claims Continued

- Forms and documentation that must be submitted where injured employee dies before total compensation is paid – N.C. Gen. Stat. § 97-37
  - Form 26D – Agreement for Payment of Unpaid Compensation in Unrelated Death Cases
  - Death Certificate
  - Marriage Certificate
  - Divorce Decree
  - Birth Certificate

Rejected Filings

Attached please find documents recently submitted by you through EDFP as well as the corresponding document receipt. The document(s) actually submitted are not consistent with the document(s) noted on the document receipt and thus the document(s) are being rejected and will be deleted from our system.

Please check the document(s) you are attempting to file for the correct IC file number, claimant name, and/or the correct document type before resubmitting them. If you need filing assistance, please don't hesitate to call.

Claims Administration Staff

- **Asia Prince**, Director
- **Shirley Pennell**, Administrative Assistant
- **Gayla Parks**, Processing Assistant, Form 18s & Coverage Research
- **Amelia Stoneking**, Processing Assistant, Form 18s & Forms Email
- **Greta Johnson**, Processing Assistant, Form 18s & EDFP
- **Deborah** Parker, Processing Assistant, Form 18s
- **Susan DeAllaume**, Processing Assistant, Form 18s
- **Thao Treslar**, Processing Assistant, Form 18s
- **Marcia Young**, Processing Assistant, Form 18s
- **Givanni Holmes**, Processing Assistant, Form 18s
- **Stefani Bennett**, Processing Assistant, Form 19s
- **Jennifer Smith**, Processing Assistant, Form 19s and Form 6Xs
- **Corina McLaughlin**, Processing Assistant, Form 6Xs
- **Gwendolyn Herndon**, Processing Assistant, Form 18Bs & Coverage Research
- **Brad Honeycutt**, Processing Assistant, Sanctions
- **Rose Frazier**, Lead Claims Examiner
- **Mae Alexander**, Claims Examiner
- **Shirley Bullock**, Claims Examiner
- **Chantile Stevens**, Claims Examiner
- **Denise Joseph**, Claims Examiner

Tips for Effective Form 24 and Form 23 Applications

Filing Documents Related to Form 24 and Form 23 Applications

- Effective February 1, 2017, all documents related to Form 24 and Form 23 Applications MUST be filed via the Commission's Electronic Document Filing Portal ("EDFP"), pursuant to Rule 04 NCAC 10A .0108.
- Employer – Forms – Form 24 Application; Additional Documentation; Withdraw or Abeyance
- Employee – Forms - Form 24 Initial Response; Additional Documentation
- Employee – Forms – Form 23 Application; Form 23 Additional Documentation
- Employer – Forms – Form 23 Response; Additional Documentation
- Either Party – Motions – Motion for Reconsideration

Form 24 – Completing the Form

North Carolina Industrial Commission

APPLICATION TO TERMINATE OR SUSPEND PAYMENT OF COMPENSATION (G.S. § 97-18.1)

IC File # ______
Emp. Code # ______
Carrier Code # ______
Carrier File # ______

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employer FEIN ______

Employee's Name | Employer's Name | Telephone Number

Address | Employer's Address | City | State | Zip

City | State | Zip | Insurance Carrier

Home Telephone | Work Telephone | Carrier's Address | City | State | Zip

XXX-XX- | ☐ M ☐ F | / / | Carrier's Telephone Number | Fax Number

Last 4 Digits of SSN | Sex | Date of Birth

IMPORTANT NOTICE TO EMPLOYEE: YOUR BENEFITS MAY BE STOPPED UNLESS YOU OBJECT IMMEDIATELY. IF YOU BELIEVE YOUR BENEFITS SHOULD NOT BE STOPPED, YOU MUST FILL OUT SECTION B. OF THIS FORM AND RETURN ONE COPY OF THIS FORM TO THE INDUSTRIAL COMMISSION. IF THE INDUSTRIAL COMMISSION HAS NOT RECEIVED THE COMPLETED COPY OF THIS FORM FROM YOU BY ______ YOUR BENEFITS MAY BE STOPPED WITHOUT FURTHER NOTICE TO YOU. IF YOU OBJECT, YOU MAY HAVE THE RIGHT TO AN INFORMAL HEARING BY THE INDUSTRIAL COMMISSION BEFORE YOUR BENEFITS CAN BE STOPPED. (THE DATE TO BE INSERTED ABOVE BY THE EMPLOYER OR CARRIER/ADMINISTRATOR SHALL BE AT LEAST 17 DAYS AFTER THIS APPLICATION WAS ELECTRONICALLY FILED WITH THE INDUSTRIAL COMMISSION.)

SECTION A. <u>TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR:</u>

1. Date of injury by accident : ______ Date disability began : ______
2. Nature and extent of injury: ______
3. Number of weeks compensation paid: ______ From : ______ To : ______
4. Total amount of indemnity compensation paid to date: $ ______
5. Check applicable box(s):
   - ☐ a. An agreement was approved by the Industrial Commission on ______
   - ☐ b. The employer admitted employee's right to compensation pursuant to N.C. Gen. Stat. § 97-18(b).
   - ☐ c. The employer paid compensation to employee without contesting claim within the statutory period provided under N.C. Gen. Stat. § 97-18(d).
   - ☐ d. Other: ______
6. Application is made to ☐ terminate or ☐ suspend compensation to the employee on the grounds that ______
7. ☐ Check box if employee is in managed care.

ATTORNEYS/CARRIERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

EMPLOYEE FILING OPTIONS:
E-MAIL TO EXECSEC@IC.NC.GOV
FAX TO (919) 715-0282
MAIL TO NCIC-EXECUTIVE SECRETARY
4336 MAIL SERVICE CENTER
RALEIGH, NC 27699-4336

HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 24
05/2017
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FORM 24

- Almost 300 Form 24 Applications were deemed incomplete in 2016.
- Make sure the most recent form is used (currently 5/2017).
- Include the response date at least 17 days after submission (see 04 NCAC 10A .0404(c)).
- TTD must be ongoing at the time of the Application. If compensation has been stopped, no ruling will be made.

Form 24 – Tips for Effective Applications

- Double check service of the Form 24 Application. Make sure the correct address/email address/fax number is used.
- Include documentation for each element of your argument.
- Only file a Form 24 when temporary TOTAL disability compensation is being paid. Do not file a Form 24 if compensation has been stopped or temporary partial compensation is being paid.
- If the employee has returned to work, file a Form 28 or Form 28T, not a Form 24.

Form 23 – Completing the Form

North Carolina Industrial Commission

APPLICATION TO REINSTATE PAYMENT OF DISABILITY COMPENSATION (G.S. § 97-18(k))

IC File #____________
Emp. FEIN #____________
Carrier FEIN #____________
Carrier File #____________

Employee's Name | Employer's Name | ( ) Telephone Number
Address | Employer's Address | City | State | Zip
City | State | Zip | Insurance Carrier
( ) Home Telephone | ( ) Work Telephone | Carrier's Address | City | State | Zip
XXX-XX- Last 4 Digits of SSN | ☐ M ☐ F Sex | / / Date of Birth | ( ) Carrier's Telephone Number | ( ) Fax Number

IMPORTANT NOTICE TO EMPLOYER: The employee in this claim has applied for reinstatement of compensation. If the employer or carrier believes that compensation should not be reinstated, the employer or carrier must respond to this Application by completing Section B of this Form and returning one copy to the Industrial Commission. If the Industrial Commission has not received the completed copy of this Form from the employer or carrier by ____________, an Order may be issued reinstating compensation. If the employer or carrier timely objects to reinstatement, the matter will be scheduled for informal telephonic hearing. (The date to be inserted above by the employee shall be 17 days after this Application was sent to the employer or carrier and Industrial Commission, whether by mail, facsimile, or e-mail.)

SECTION A. TO BE COMPLETED BY THE EMPLOYEE:

1. Date of injury by accident or occupational disease: ____________
2. Nature and extent of injury or occupational disease: ____________
3. (a) Has your claim been accepted or determined to be compensable by the Industrial Commission: Yes: ☐ No: ☐
   (b) If so, how: Form 21 ☐ Form 60 ☐ Form 63 ☐ Opinion and Award ☐
   Other____________
4. Number of weeks compensation already paid: ______ From:____/____/____ To:____/____/____
5. Date from which seeking compensation:____________
6. Application is made to reinstate compensation on the grounds that:____________

YOU MUST ATTACH DOCUMENTATION TO SUPPORT THIS APPLICATION FOR REINSTATEMENT OF COMPENSATION.
NUMBER OF PAGES ATTACHED: ____________

GIVE A TELEPHONE NUMBER AT WHICH YOU CAN BE REACHED IF AN INFORMAL HEARING IS SCHEDULED, FROM MONDAY THROUGH FRIDAY BETWEEN 8:00 A.M. AND 5:00 P.M.: ____________ THE INDUSTRIAL COMMISSION WILL NOTIFY YOU IF AN INFORMAL HEARING IS SCHEDULED.

IN ADDITION TO FILING THE ORIGINAL OF THIS APPLICATION AND SUPPORTING DOCUMENTS WITH THE INDUSTRIAL COMMISSION, I HEREBY CERTIFY THAT A COPY OF THIS APPLICATION, TOGETHER WITH ALL SUPPORTING DOCUMENTS, WAS SENT TO THE EMPLOYER OR CARRIER/ADMINISTRATOR AT: (ADDRESS/FAX NO):____________

SIGNATURE OF EMPLOYEE OR ATTORNEY:____________ DATE:____________

ATTORNEYS/CARRIERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

EMPLOYEE FILING OPTIONS:
E-MAIL TO EXECSEC@IC.NC.GOV
FAX TO (919) 715-0282
MAIL TO NCIC-EXECUTIVE SECRETARY
4336 MAIL SERVICE CENTER
RALEIGH, NC 27699-4336

HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 23
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FORM 23

- Claims must be accepted or liability established in order to reinstate benefits.
- Include the response date at least 17 days after submission (see 04 NCAC 10A .0405(b)).
- Include dates of compensation previously paid and the date from which seeking reinstatement of compensation.

Form 23 – Tips for Effective Applications

- Double check service of the Form 23 Application. Make sure the correct address/fax number is used.
- Include documentation for each element of your argument.
- Include copies of Commission forms and check stubs referenced in your argument.
- If seeking a late-payment penalty, be sure to include it in your argument.

Guidelines for Completion
of Other Forms Filed
with the Executive Secretary's Office

Form 28U – Unsuccessful Trial Return to Work

- The employee may file a Form 28U to request reinstatement of compensation following an unsuccessful trial return to work.
  - N.C. Gen. Stat. § 97-32.1: "If the trial return to work is unsuccessful, the employee's right to continuing compensation under G.S. 97-29 shall be unimpaired unless terminated or suspended thereafter pursuant to […] this Article."
  - This form may follow a Form 28T, Notice of Termination of Compensation by Reason of Trial Return to Work, filed by the carrier.
- The Form 28U must be completed and signed by the employee and the authorized treating physician and sent to the carrier and the IC.
- Rule 404: "Upon receipt of a completed Form 28U…, the [carrier] shall resume payment of compensation…."
  - Reinstate from the date the carrier receives the completed Form 28U.
  - If contested, carrier must reinstate and then file a Form 24 Application.

Form 42 – Application for Appointment of Guardian *ad Litem*

- The applicant can be, but does not have to be, the proposed GAL.
- Common issues:
  - Failing to complete the plaintiff and defendant caption section.
  - Failing to check the box for infant or incompetent.
  - Failing to fill out the contact information for the plaintiff and proposed GAL.
- Carriers may contact the IC to request consideration of the appointment of a GAL if they have concerns about plaintiff's competence or conflicts of interest between a minor and parent/guardian.
- In the absence of a suitable proposed GAL, the IC will appoint one.

Form 18M – Application for Additional Medical Compensation

- N.C. Gen. Stat. § 97-25.1: "The right to medical compensation shall terminate two years after the employer's last payment of medical or indemnity compensation unless, prior to the expiration of this period, either: (i) the employee files with the Commission [a Form 18M that is] approved by the Commission, or (ii) the Commission on its own motion orders additional medical compensation. If the Commission determines that there is a substantial risk of the necessity of future medical compensation, the Commission shall provide by order for payment of future necessary medical compensation."

- A certain portion of the Form 18M Applications we receive are requests for additional CURRENT medical compensation.
  - Such requests should be filed as motions to medicalmotions@ic.nc.gov.

Form 18M – Application for Additional Medical Compensation

- Rule 04 NCAC 10A .0408:
  - Commission sends carrier notice and a copy of the Form 18M.
  - Carrier has 30 days to respond and indicate whether the claim is accepted or denied.
  - If carrier denies the Form 18M, carrier may state the grounds for denial and attach any supporting documentation.
- Common issues:
  - Incomplete Section A because no reason given or no employee signature.
  - Section B.2. is blank and there is insufficient medical documentation of projected future medical care.
  - Signed by someone other than the treating physician.

Form 90 – Report of Earnings

- N.C. Gen Stat. § 97-88.2 and Rule 04 NCAC 10A .0903
- Carrier may send an employee who is receiving compensation a Form 90 when reasonably necessary but not more than once every six months.
- The Form 90 must be sent to the employee by certified mail, return receipt requested, and include a self-addressed stamped envelope for the return of the form. If employee is represented, send to the attorney only.
- If the employee fails to return the Form 90 within 30 days, carrier may seek an order allowing the suspension of benefits.
- If plaintiff thereafter returns a completed Form 90, benefits must be retroactively reinstated.
- Carrier may seek termination/modification of benefits via Form 24/33.

Form 90 – Report of Earnings

- TIPS for carriers:
  - Document compliance with the mailing requirements in a cover letter to employee accompanying the Form 90.
  - Fill out the "TIME PERIOD COVERED BY THIS REPORT" at the bottom of the first page.
  - Reinstate benefits immediately upon receipt of a completed Form 90 to avoid late payment penalties.
  - Rule 04 NCAC 10A .0903 does not require the filing of a Form 24 to suspend compensation when the employee does not return the Form 90.
    - Carrier may file Motion to Suspend Compensation or Form 24.