Carrier Code # Carrier File # The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act Employee's Name Employee's Name Employer's Name Employer's Name Employer's Name Employer's Name Employer's Name City State City State City State Carrier's Address City Carrier's Address City State Carrier's Address City Carrier's Ad							IC File #			
The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act Employee's Name	AGREEMENT FOR COMPENSATION FOR DISABILITY Emp. Code #									
The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act Employer's Name								Carrier Code #		
Employer's Name City State City Courred Compensation Act and Interior Interior City Cin	G.S	S. § 97-82)						Carrier File #		
City State Zip Insurance Carrier	he U	se of This Form	ı Is Required Un	der the Provis	ions of th	ne Worl	cers' Compensation Act			_
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Home Telephone	ddress	;				Emplo [,]	yer's Address	City	State	Zip
Mark Park		City		State	Zip	Insurar	nce Carrier			
Last 4 Digits of SSN Sex Date of Birth Carrier's Telephone Number Fax Number	lome Te	elephone		Work Telepho	ne	Carrier	's Address	City	State	Zip
We, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS: 1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and is the carrier/administrator for the employer. 2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on or by 3. The injury by accident or occupational disease resulted in the following injuries: 4. The employee □ was/□ was not paid for the entire day when the injury occurred. 5. The average weekly wage of the employee at the time of the linjury, including overtime and all allowances, was \$ subject to verification unless otherwise agreed upon in line 9 below. 6. Disability resulting from the injury or occupational disease began on						()		()		
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Name Of Carrier / Administrator Signature By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form. Signature of Employee Address Signature of Employee's Attorney Address North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved:	. Th Th Th S Dist Th On On Sta	ne injury by accident the employee was, the average weekly to be ability resulting from the employer and caper we are employee has the any further mat applicable, the Section in the injury of the employee was the employee was the any further mat applicable, the Section in the injury of the injur	ant or occupational di s/ □ was not paid for wage of the employ , subject to ver come the injury or occur carrier/administrator have beek beginning , at an au tters agreed upon, i	r the entire day wi yee at the time of ification unless of cupational disease hereby undertake d to work for verage weekly wa including disfigure	when the injury, otherwise age began on the to pay cor	jury occur includin greed upon mpensation	rred. ng overtime and all allowances, on in line 9 below. ion to the employee at the rate of, and continuing for partial, or temporary partial disabi	f ility: attached.	 _weeks.	
By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form. Signature of Employee Address Signature of Employee's Attorney Address North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved:	lame C	Of Employer		Signatu	ire		Title			
Signature of Employee Address Address Morth Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved:	lame C	Of Carrier / Adminis	strator	Signatu	ıre		Title			
Signature of Employee's Attorney Address North Carolina Industrial Commission THE FOREGOING AGREEMENT IS HEREBY APPROVED:	y signi	ing I enter into this a	agreement and certif	y that I have read f	the "Import	ant Notice	es to Employee" printed on Page 2	of this form.		
NORTH CAROLINA INDUSTRIAL COMMISSION THE FOREGOING AGREEMENT IS HEREBY APPROVED: CHECK BOX IF NO ATTORNEY RETAINED.	ignatu	ire of Employee			Address					
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CHECK BOX IF NO ATTORNEY RETAINED.	'S	10 01 <u>— — — , </u>	monie,		144.					
CLAIMS EVAMINED DATE	СНЕ	ECK BOX IF NO ATTO	ORNEY RETAINED.							
CHECK BOX IF EMPLOYEE IS IN MANAGED CARE.							CLAIMS EXAMINER		DATE	

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SELF INSURED EMPLOYER OR CARRIER,

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL (EDFP)

ATTORNEY'S FEE APPROVED

HTTPS: //WWW.IC.NC.GOV/DOCFILING.HTML

CONTACT INFORMATION:

NCIC- CLAIMS ADMINISTRATION TELEPHONE: (919)807-2502 HELPLINE: (800) 688-8349

WEBSITE: HTTPS://WWW.IC.NC.GOV

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5,1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must file an application for additional medical compensation pursuant to G.S. 97-95.1 within two years, or your right to these benefits may be lost. An application for additional medical compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33, Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

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