IC File #_____

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

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:_____



**FORM 23**

***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***
***1236 MAIL SERVICE CENTER***
***RALEIGH, NC 27699-1236***

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

I.C. NO. _____

**SECTION B. TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR**

1. THE EMPLOYER/CARRIER MUST COMPLETE EITHER 1.(a) OR 1.(b)

   (a) If reinstatement of compensation is not contested, complete the following:

   Compensation in the amount of $_____ per week was or will be reinstated from _____/_____/_____

   commencing on: _____/_____/_____

   If compensation is reinstated on a date other than the date requested by the employee in Section A.5., please explain:_____
   _____
   _____
   _____

   (b) Compensation should not be reinstated because:_____
   _____
   _____
   _____

2. (a) Specify whether this claim has been accepted, denied or determined compensable by the Industrial Commission:_____
   _____

   (b) How: Form 61 ☐ Form 21 ☐ Form 60 ☐ Form 63 ☐ Opinion and Award ☐

   Other_____

3. If compensation has been paid, provide the number of weeks: _____From:_____/_____/_____To:_____/_____/_____

IF REINSTATEMENT OF COMPENSATION IS CONTESTED, GIVE A TELEPHONE NUMBER AT WHICH YOU CAN BE REACHED WHEN THE INFORMAL HEARING IS SCHEDULED, FROM MONDAY THROUGH FRIDAY BETWEEN 8:00 A.M. AND 5:00 P.M. _____ AND A FACSIMILE NUMBER OR E-MAIL ADDRESS FOR SERVICE OF THE HEARING NOTICE AND ANY OTHER CORRESPONDENCE:

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IN ADDITION TO FILING THE ORIGINAL OF THIS RESPONSE WITH THE INDUSTRIAL COMMISSION, I HEREBY CERTIFY THAT A COPY OF THIS RESPONSE, TOGETHER WITH SUPPORTING DOCUMENTS, WAS SENT TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY, AT (ADDRESS/FAX NO:)_____

_____

ON _____

SIGNATURE OF EMPLOYER,
CARRIER/ADMINISTRATOR OR
ATTORNEY:_____DATE:_____



# FORM 23

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