**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 |
| Social Security Number / Sex (M ☐ F ☐) / Date of Birth (/ /) | Carrier's Telephone Number / Fax Number |

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

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*
*4333 MAIL SERVICE CENTER*
*RALEIGH, NC 27699-4333*

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



**FORM 24**

In addition to filing this application and supporting documents with the Industrial Commission, I hereby certify that a copy of this application, together with all supporting documents, was served on the employee via Standard U. S. Mail, at:

(address) _____

(city, state, zip) _____

***OR*** on the employee's attorney of record, if any, by e-mail or facsimile to:

_____
(email address or fax number served)

On the day of: _____. The attached documents consist of _____ pages.
(date) (number)

_____
SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR PRINTED NAME TELEPHONE NUMBER DATE

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**TO BE COMPLETED BY THE EMPLOYEE**

**SECTION B. IF YOU THINK YOUR COMPENSATION SHOULD NOT BE STOPPED, YOU SHOULD COMPLETE THIS SECTION.**

1. I do not think my compensation should be stopped because: _____

_____

_____

_____

2. Enclose and specify the number of pages of documents the Industrial Commission should consider: _____

3. Please provide 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..The Industrial Commission will notify you of the date and time of the hearing.

   Your telephone number: _____.

_____
SIGNATURE OF EMPLOYEE DATE

If you need assistance in completing this form, you may contact the Industrial Commission at (800) 688-8349. You must contact the Office of the Executive Secretary at (919) 807-2657 to obtain an extension of time in which to submit medical records, or to obtain documents you have not been able to obtain.

EMPLOYEE: SEND A COPY OF THIS FORM AND SUPPORTING DOCUMENTS TO THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU ARE RECEIVING COMPENSATION. **FILE THE ORIGINAL WITH THE INDUSTRIAL COMMISSION AS INSTRUCTED AT THE BOTTOMOF THE FORM.**



# FORM 24

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