

SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION (G.S. §97-82)

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, Address, City, State, Zip, Home Telephone, Social Security Number, Sex, Date of Birth, Employer's Name, Telephone Number, Employer's Address, City, State, Zip, Insurance Carrier, Carrier's Address, City, State, Zip, Carrier's Telephone Number, Fax Number

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

- 1. Date of injury:
2. The employee returned to work / was rated on (date), at a weekly wage of \$
3. The employee became totally disabled on
4. Employee's average weekly wage was reduced / was increased on, from \$ per week to \$ per week.
5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of \$ per week beginning, and continuing for weeks. The type of disability compensation is
6. State any further matters agreed upon, including disfigurement or temporary partial disability:
7. The date of this agreement is

NAME OF EMPLOYER SIGNATURE TITLE
NAME OF CARRIER/ADMINISTRATOR SIGNATURE TITLE

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on the reverse side of this form.

SIGNATURE OF EMPLOYEE ADDRESS
SIGNATURE OF EMPLOYEE'S ATTORNEY ADDRESS

Check box if no attorney retained.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:
CLAIMS EXAMINER DATE
ATTORNEY'S FEE APPROVED

**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 5 JULY 1994
CLAIMING ADDITIONAL MEDICAL BENEFITS**

If your injury occurred before 5 July 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 5 JULY 1994
CLAIMING ADDITIONAL MEDICAL BENEFITS**

If your injury occurred on or after 5 July 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 apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

IMPORTANT NOTICE TO EMPLOYER

This form is to be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Failure to file Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after last payment pursuant to this agreement may subject the employer or carrier/administrator to a penalty. Pursuant to Rule 501, 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, or show good cause for not submitting the agreement.

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.