North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

Employer FEIN _____

REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF COMPENSATION AND MEDICAL COMPENSATION PAID PURSUANT TO A COMPROMISE SETTLEMENT AGREEMENT

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

THIS FORM IS ONLY TO BE USED IN SETTLED CASES

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 / /	( ) ( )
Last 4 Digits of SSN Sex Date of Birth	Carrier's Telephone Number Fax Number

1. Date of accident or disability from occupational disease _____.
2. Salary ☐ was / ☐ was not continued. Total Dollar Amount
3. Number of weeks temporary total _____ from _____ , through _____ $_____
   _____ from _____ , through _____ $_____
4. Number of weeks temporary partial _____ from _____ , through _____ $_____
   _____ from _____ , through _____ $_____
5. Number of weeks permanent partial _____ from _____ , through _____ $_____
6. Disfigurement amount paid $_____
7. Loss of organ or body part benefits paid $_____
8. TOTAL OF LINES 3 THROUGH 7 $_____
9. Compromise Settlement Agreement amount $_____
10. Total Medical Paid $_____

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

SIGNATURE TITLE DATE

This form must be filed with the Industrial Commission at the address below.

FOR INDUSTRIAL COMMISSION USE ONLY	
Days	_____
Compensation Paid	$_____
Medical	$_____
IC Code:	_____

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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 28C