SUPPLEMENTAL REPORT FOR FATAL ACCIDENTS (FORM 19, EMPLOYER'S REPORT OF EMPLOYEE'S INJURY TO THE INDUSTRIAL COMMISSION, MUST ALSO BE SUBMITTED IN EVERY CASE)

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

-		
Emp. Code #		

IC File #

Carrier Code #

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence. Code numbers assigned to each employer and carrier should be inserted before mailing.

				inserted t	inserted before mailing.		
				()		
Deceased Employee's Name			Employer's Name		Tel	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 I	Number	
Date of accident:			2. Date of death:			, 2	0
3. Dependents, or if e	employee left no de	ependents, next of kin: (Ir	ndicate which are non-residen	t aliens)			
	Name	Date of Birth	Relationship	Present	t Addres	S	
a							
b			<u> </u>				
C							
d							
e							
f			<u> </u>				
4. Immediate cause of	of death:						
5. Amount of burial o	vnancas authoriza	d ¢					
5. Amount of burial e	xpenses aumonze	u					

Title

FORM 29 03/2020 FORM 29 Page 1 of 1

Signature of Employer or Carrier/Administrator

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

Date

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

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