North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

NOTICE OF REINSTATEMENT OR MODIFICATION OF COMPENSATION (G.S. § 97-32.1 OR § 97-18(b))

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

Employee's Name			Employer's Name		( ) - Telephone Number
Address			Employer's Address	City	State Zip
City	State	Zip	Insurance Carrier	Policy Number	
( ) - 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	
Date of Injury:					

Compensation in the amount of $. per week was reinstated or modified on _____ pursuant to ☐ N.C. Gen. Stat. § 97-32.1

or

☐ N.C. Gen. Stat. § 97-18(b).

Give reason for reinstatement:

The employee's average weekly wage, including overtime and all allowances, was $. , which results in a weekly compensation rate of $.

☐ a. Temporary total compensation is being paid at the compensation rate above.

☐ b. Temporary partial compensation is being paid in the amount of $.

☐ c. Other: _____

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR	TITLE	/ / DATE

Employer: The original of this form must be sent to the Industrial Commission at the address below. A copy shall be provided to the employee and the employee's attorney of record, if any.

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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