NCIC 13th Annual Workers' Compensation Conference
October 2008

New & Revised

FORMS & PROCEDURES

PRESENTATION OVERVIEW

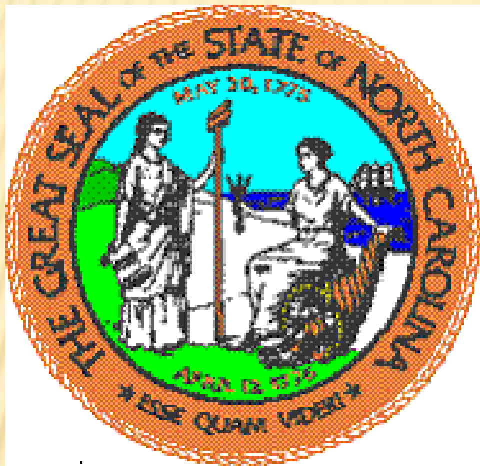
- WHAT are the new or revised forms & procedures?
- WHEN was the effective date?
- WHO developed it?
- WHY were the new forms & procedures necessary?
- HOW does it affect my business practices?
- WHERE can I get additional information?

Keep in mind…

- The new forms and procedures are applicable to…
  - Employers
  - Carriers
  - Third Party Administrators
  - Self-insured employers
  - Any entity that handles a workers' compensation claim
- *Even if* you did not send in the initial forms

Effective Date

August 1, 2008



North Carolina

Industrial Commission

REVISED FORMS

- FORM 18
- FORM 19
- FORM 60
- FORM 25R
- FORM 26

FORM 18

North Carolina Industrial Commission

IC File #__________

Emp. Code #__________

Carrier Code #__________

Employer FEIN__________

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.

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT (G.S. §§97-22 THROUGH 24)

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

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

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: ________ (Time of Injury) on __/__/__ (Date (required)) at ________ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) ________

Describe how the injury or occupational disease occurred: ________

Occupation when injured: ________ Nature of employer's business: ________

Number of days out of work due to injury:

Medical treatment received? ☐Yes ☐No

Weekly wage: $______ Number of hours worked per day: ______ Days worked per week: ______

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent — ( ) - Telephone Number

Address — City — State — Zip — / / Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY
RESEARCHER: ____
CC: ____
EC: ____
DATA ENTRY: ____

FORM 18
8/6/08
PAGE 1 OF 1

FORM 18

MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

Changed "date disability began" to "Number of days out of work due to injury"

Other Changes:

Address
Website
"For IC Use Only" Box;
Coding Box Removed

FORM 19

Carrier Code & Emp. Code Requirement Notice

Instructions Language Revised

Similar Changes as F18

North Carolina Industrial Commission

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

IC File #__________
*Emp. Code #__________
*Carrier Code #__________
Employer FEIN__________
Carrier File #__________

***Required Information.**

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.

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law. This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

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

Employer
1. Give nature of employer's business

Time And Place
2. Location of plant where injury occurred
County Department State if employer's premises
3. Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
5. Was employee paid for entire day 6. Date disability began / / ☐ A.M. ☐ P.M.
7. Date you or the supervisor first knew of injury / / 8. Name of supervisor

Person Injured
9. Occupation when injured
10. (a) Time employed by you (b) Wages per hour $
11. (a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week
(d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per

Cause And Nature Of Injury
12. Describe fully how injury occurred and what employee was doing when injured:
(Statement made without prejudice and without vouching for correctness of information)
13. List all injuries and specify body part involved (e.g. right hand or left hand):
14. Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
16. At what occupation 17. Employee's salary continued in full?
18. Was employee treated by a physician

Fatal Cases
19. Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name ________ Date Completed / /
Signed by ________ Official Title ________

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FORM 19
8/6/08
PAGE 1 OF 2

For IC Use Only
Researcher: ____
CC: ____
EC: ____
Data Entry: ____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

"ACORD" Form

Universal First Report Of Injury form

- 15-17 states

- Distributed by IAIBAC
- Used in software packages
- Information source for electronic submission

FORM 60

North Carolina Industrial Commission

EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO COMPENSATION (G.S. §97-18(b))

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

IC File #______
Emp. Code #______
Carrier Code #______
Carrier File #______
Employer FEIN ______

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

TO DEFENDANTS: Describe with particularity the body part(s) or condition(s) for which you are admitting liability and compensability.
TO EMPLOYEE: Your employer admits your right to compensation for an
☐ injury by accident on __/__/____ (date) to __/__/____
☐ occupational disease on __/__/____ (date) to __/__/____

THE FOLLOWING ITEMS 1 THROUGH 4 ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT:

1. The description of the injury or occupational disease, including body parts involved is:
2. The employee was paid for the entire day of injury. ☐ Yes ☐ No
3. The employee's average weekly wage, subject to verification, 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: ______________________
4. The disability resulting from the injury began on __/__/____ (date), and compensation commenced on __/__/____ (date).

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR | TITLE | DATE / /

EMPLOYER: Failure to file Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after last payment pursuant to an agreement or award subjects employer or carrier/administrator to a penalty pursuant to N.C. Gen. Stat. § 97-18(h). Form 30 must be used for compensable injuries resulting in death. A copy of this Form 60 shall be provided to the employee and the employee's attorney of record, if any, and the original provided to the Industrial Commission at the address below.

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8/6/08
PAGE 1 OF 1

FORM 60

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

Must identify specific body part

Medical only box removed (See Form 63)

FORM 25R

North Carolina Industrial Commission

EVALUATION FOR PERMANENT IMPAIRMENT

IC File #__________
Emp. Code #__________
Carrier Code #__________
Carrier File #__________
Employer FEIN__________

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

Employee's Name
Address
City State Zip
( ) Home Telephone ( ) Work Telephone
Social Security Number ☐ M ☐ F Sex / / Date of Birth
Date of Injury: __________

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

EMPLOYEE'S WORK-RELATED INJURY WILL RESULT IN:

MEMBER	% OF IMPAIRMENT (IF AMPUTATION, DESCRIBE ON REVERSE.)
1) Thumb	
2) Index Finger	
3) Middle Finger	
4) Ring Finger	
5) Little Finger	
6) Great Toe	
7) Toes (other than great toe)	
8) Hand	
9) Arm	
10) Foot	
11) Leg	
12) Back	

Physician Signature
Printed Name
Fed. Tax ID Number
Date
Address

In regard to this rated body part:
1) Is employee at maximum medical improvement? ______
2) Was employee released with restrictions? ______

TEETH: Age of employee: ______
List all crowns by number : ______
List all extractions by number : ______
Has dental work been completed? ☐ Yes ☐ No

VISION: List vision reading without the use of a corrective lens.
Distance: ______ Near: ______

HEARING: Scale used: ______ Percentage of loss: Right ear ______
PLEASE ATTACH AUDIOGRAMS AND CALCULATIONS OF HEARING LOSS Left ear ______

OTHER: Permanent injury to or impairment of any other organ or part of body (identify) : ______
Disfigurement: ☐ Yes ☐ No Location: ☐ face ☐ head ☐ body

FORM 25R
8/6/08
PAGE 1 OF 2

FORM 25R

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS SECTION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

Doctor must answer:

1. MMI?
2. Permanent Restrictions?

No changes to 2nd page

FORM 25A

North Carolina Industrial Commission

CERTIFICATION OF MATERIAL MEDICAL AND VOCATIONAL RECORDS (G.S. §97-82)

THIS FORM MUST BE SUBMITTED WITH A FORM 21 OR FORM 26 FOR APPROVAL OF A PERMANENT PARTIAL DISABILITY RATING

IC File # ____
Emp. Code # ____
Carrier Code # ____
Carrier File # ____
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

Regarding Permanent Partial Disability Rating on a Form 21 or Form 26

The undersigned hereby certify that the material medical and vocational reports related to the injury have been provided to the employee or his attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Industrial Commission Rule 501(3).

Printed Name of Individual Signing for: Employer/Carrier/Administrator/Attorney (Circle One) | Signature | Title | Date

Printed Name of Employee or Employee's Attorney (Circle One) | Signature | Title | Date

Form 25A
10/2005
Page 1 of 1

Form 25A

NCIC – Claims Section
4335 Mail Service Center
Raleigh, NC 27699-4335
Fax: (919) 715-0283
Main Telephone: (919) 807-2500
Ombudsman: (800) 688-8349

- Discontinued

FORM 26

North Carolina Industrial Commission

Supplemental Agreement as to Payment of Compensation (G.S. §97-82)

IC File # ______
Emp. Code # ______
Carrier Code # ______
Carrier File # ______
Employer FEIN ______

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
( ) Home Telephone | ( ) Work Telephone | Carrier's Address | City | State | Zip
Social Security Number | ☐ M ☐ F Sex | / / Date of Birth | ( ) 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

Form 26
8/6/08
Page 1 of 2

Form 26

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

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.

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Form 26

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

Certification replaces Form 25A

RESPONDING TO THE FORM 18

- SANCTIONS PROCEDURE
- REVISED FORM 63

What happens when a Form 18 is received?

- Research
  - Check Form 18 for necessary information
  - Check database for duplicate claim
  - Verify employer code
  - Verify insurance coverage with IC & N.C. Rate Bureau database
- Data Entry & File Number Assignment

The Acknowledgment Letter

- A letter is sent to the employee or plaintiff’s attorney
  - Confirms receipt of the Form 18
  - Informs of the IC file number
  - Notifies plaintiff that a copy of Form 18 is being sent to employer
  - Contains sanctions notice
- Copy of this letter and Form 18 is sent to employer

Responding to the Form 18

- Form 21, Agreement for Compensation of Disability
- Form 60, Employer's Admission of Employee's Right to Compensation
- Form 61, Denial of Claim
- Form 63, Notice to Employee of Payment of Compensation Without Prejudice or Payment of Medical Benefits Only Without Prejudice

Submitting the Form

- Forms@ic.nc.gov
- 4335 Mail Service Center, Raleigh, N.C. 27699
- Do not fax any forms unless you are working on a particular matter with Claims Administration personnel

The Sanctions Process

- Form 21, 60, 61 or 63 must be filed within 30 days of the Form 18 acknowledgment letter date
- If not, sanction order is entered
- Ten business days to file the appropriate form & have sanction lifted
- After ten business days, an order lifting the sanction will be entered or the sanction will be invoiced

Sanction will be lifted…

- File Form 21, 60, 61, 63
- Duplicate claim & Form 21, 60, 61 or 63 filed in duplicate file
- Wrong carrier identified
- Plaintiff files for voluntary dismissal without prejudice

Sanctions: Other Information

- Amount: $200.00
- Began with August 1, 2008 Acknowledgment letters

FORM 63

- Two Options
  - Pay Indemnity Compensation & Medical Benefits (N.C. Gen. Stat. 97-18(d))
    - No change in the governing legal principles
      - 90 day investigation from actual or written notice
      - Extension of up to 30 days
        - Extension request is now filed with Director of Claims Administration instead of Executive Secretary
  - New Option—Payment of Medical Benefits without prejudice and not subject to 90-days

FORM 63: MEDICAL ONLY OPTION

- May be used to respond to Form 18 when claimant not yet entitled to TTD
- Form 63 may be used for medical only claims
- No time limitation
  - Not subject to 90 days
  - Decision to file F60 or F61 occurs when the seven day waiting period for TTD is met
- Does not "convert to a 60" after 90 days
- Does not affect Form 19 rules

FORM 63

Entire form has changed

- Specific body part must be identified
- Two options provided
- Explanation of both options

North Carolina Industrial Commission

Notice to Employee of Payment of Compensation Without Prejudice (G.S. §97-18(d)) or Payment of Medical Benefits Only Without Prejudice (G.S. §97-2(19) & §97-25)

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

IC File # ________
Emp. Code # ________
Carrier Code # ________
Carrier File # ________
Employer FEIN ________

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

To Employee (to Dependent(s) or Next of Kin in Cases of Death):

This is to inform you with regard to your claim for

☐ injury on __/__/____ (date) to __/__/____ (date) (Specify body part(s) involved):

☐ occupational disease as of __/__/____ to __/__/____ (date) (Specify condition(s) and body part(s) involved):

☐ death on __/__/____ (date)

To Employer/Carrier: Fill out only the applicable Section 1 or 2 below
Note: The following are for informational purposes only and do not constitute an agreement

Section 1: Indemnity Benefits

☐ Payments of workers' compensation benefits, both indemnity (money) and medical, will be made without prejudice to later deny your claim or Defendants' liability. Compensation may be continued during the investigation of your claim. The investigation may take up to 90 days, with a possible 30 day extension. During this period, Defendants may admit liability; contest your claim or Defendants' liability; or by Defendants' lack of action, waive the right to contest your claim.

The date on which Defendants first had written or actual notice of this claim was __/__/____(date)

Disability began on __/__/____(date) and the first payment of compensation is being mailed on __/__/____ (date)

Subject to verification, employee's average weekly wage was $_____, which results in a weekly compensation rate of $_____.

Section 2: Medical Benefits Only (paid without prejudice, NOT subject to 90-day requirement in Section 1 above)

☐ Payment of medical compensation is expressly being made without prejudice to Defendants to later deny the compensability of your claim. In the event you miss more than 7 days of work, you must notify your employer or carrier because you may be entitled to additional benefits. Completion of this section (Section 2) does not constitute an agreement to pay indemnity (money) benefits to you under G.S. §97-18(d).

The date on which Defendants first had written or actual notice of this claim was __/__/____(date).

Signature of Employer or Carrier/Administrator | Title | / / Date

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8/6/08
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Form 63

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

FORM 63: SPECIFIC SITUATIONS

- Claimant has met waiting period
  - 90 days from actual or written notice
    - Has passed
      - Must file 60 or 61, can not file Form 63 indemnity option
    - Has not passed
      - Must file a Form 60, 61 or 63, indemnity option
      - The Form 63 investigation period is limited by the number of days left in the 90 days from actual or written notice

FORM 26A

This language replaces Form 25A

North Carolina Industrial Commission

Employer's Admission of Employee's Right to Permanent Partial Disability (G.S. §97-31)

IC File # ___________
Emp. Code# ___________
Carrier Code# ___________
Carrier File #___________
Employer FEIN ___________

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

Employee's Name
Address
City State Zip
Home Phone Work Phone
Social Security Number M F Date of Birth

Employer's Name Phone
Employer's Address City State Zip
Insurance Carrier
Carrier's Address City State Zip
Carrier's Telephone Number Ext. Carrier's Fax Number

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

1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and __________________ is the Carrier/Administrator for the Employer.
2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on __________________.
3. The injury by accident or occupational disease resulted in the following injuries: ________________________________.
4. The employee ☐ was ☐ was not paid for the 7 day waiting period. If not, was salary continued? ☐ yes ☐ no. Was employee paid for the date of injury? ☐ yes ☐ no
5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $____________. This results in a weekly compensation rate of $____________.
6. The employee ☐ has ☐ has not returned full time to work for ______________________ on __________________, at an average weekly wage of $________________.
7. Claimant was released ☐ with permanent restrictions ☐ without permanent restrictions.
8. Permanent partial disability compensation will be paid to the injured worker as follows:

   ____ weeks of compensation at rate of $_______ per week for ____% rating to __________ (body part)
   ____ weeks of compensation at rate of $_______ per week for ____% rating to __________ (body part)
   ____ weeks of compensation at rate of $_______ per week for ____% rating to __________ (body part)

Total amount of permanent partial disability compensation is $__________. Date of first payment:____________.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: ________________________________.

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Form 26A

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:
NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.COMP.STATE.NC.US/

10. An overpayment is claimed in the amount of $____________. Overpayment was calculated as follows:________________________________. If overpayment claimed, a Form 28B is attached. ☐ yes ☐ no
11. If applicable, the Second Injury Fund Assessment is $ ______________. A check ☐ is ☐ is not included.

The undersigned hereby certify that the material medical and vocational reports related to the injury have been provided to the employee or his attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Industrial Commission Rule 501(3).

Name of Employer Signature Title Date

Name of Carrier/ Administrator Signature Direct phone number Title Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on page 3 of this form.

Signature of Employee Address Date

Signature of Employee's Attorney Address Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission

The FOREGOING AGREEMENT IS HEREBY APPROVED:

NCIC Claims Examiner/ Special Deputy/ Other

$______________________
ATTORNEY FEE APPROVED

FORM 26A

- Intent was to make an easier form for payment of PPD
- Payment of permanent partial disability for injuries listed on NCGS 97-31 schedule
- Can not use for TTD or TPD
- There can be several Forms 26A in one file—a Form 26A is followed by a Form 26A

Panel Discussion

Amy Pfeiffer, Esq.

John Hedrick, Esq.

Sharon Sosebee, Asst. V.P. Claims,

Key Risk Management Services