North Carolina Industrial Commission

AGREEMENT FOR COMPENSATION FOR DISABILITY

(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 ____________________

Address ____________________

City ____________ State ______ Zip ______

( ) Home Telephone ____________ ( ) Work Telephone ____________

Social Security Number ____________ Sex ☐ M ☐ F 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. All 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 or by ____________________________.
3. The injury by accident or occupational disease resulted in the following injuries: ____________________________________
4. The employee ☐ was/ ☐ was not paid for the entire day when the injury occurred.
5. The average weekly wage of the employee at the time of the injury, **including overtime and all allowances**, was $ ________________, subject to verification unless otherwise agreed upon in line 9 below.
6. Disability resulting from the injury or occupational disease began on ____________________________________.
7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $ ________per week beginning ____________________________, and continuing for __________________weeks.
8. The employee ☐ has / ☐ has not returned to work for ____________________________________ on ____________________, at an average weekly wage of $ ________________.
9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: ____________________________________
10. If applicable, the Second Injury Fund Assessment is $ ________________. Check ☐ is ☐ is not attached.
11. The date of this agreement is ____________________. Date of first payment: ______________ Amount: ____________

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.

☐ CHECK BOX IF EMPLOYEE IS IN MANAGED CARE.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

CLAIMS EXAMINER ____________ **DATE** ____________

ATTORNEY'S FEE APPROVED ____________

SELF-INSURED EMPLOYER OR CARRIER, MAIL TO:

NCIC - CLAIMS SECTION
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

FORM 21

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 JULY 5,1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

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

If your injury occurred on or after July 5, 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

The employee must be provided a copy 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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