

# APPLICATION FOR LUMP SUM AWARD

IC File # \_\_\_\_\_

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Carrier File # \_\_\_\_\_

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

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 \_\_\_\_\_

**APPLICATION MUST BE COMPLETED IN FULL BEFORE REQUEST WILL BE CONSIDERED.**

The applicant represents that he or she has been granted an award of compensation by the North Carolina Industrial Commission, and that the award has been paid in periodical payments for not less than six weeks. The applicant hereby requests that he or she be allowed a lump-sum payment in an amount as requested below. (If the applicant desires to buy property of any kind with this lump sum settlement, three estimates of the value of the property must be submitted with the application to the Industrial Commission.)

Name: \_\_\_\_\_ Present Employer: \_\_\_\_\_

How Long: \_\_\_\_\_

Address: \_\_\_\_\_ Job Title: \_\_\_\_\_

Average Wage/Wk : \_\_\_\_\_

Are you unemployed: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Other Income (Including Spouse's): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Dependents (Names & Ages): \_\_\_\_\_

Outstanding Bills (Creditor and Amount Owed): \_\_\_\_\_

Purpose of Lump Sum Request: \_\_\_\_\_

Amount Requested \$ \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Applicant must send a copy of this form to the carrier and a copy to the Industrial Commission at the address below.**

**TO BE COMPLETED BY CARRIER/ADMINISTRATOR**

The \_\_\_\_\_ (Name Insurance Company),  agrees to pay the requested amount of \$ \_\_\_\_\_ in a lump sum without commutation, or  agrees to pay the following recommended amount of \$ \_\_\_\_\_ in a lump sum without commutation or  refuses to pay the compensation in a lump sum without commutation.

Balance due applicant (pre-lump sum): \_\_\_\_\_

**For Commission's Use Only**

|                    |
|--------------------|
| Approved By: _____ |
| Amount: _____      |
| Denied By: _____   |
| Date: _____        |

Signature \_\_\_\_\_ Title \_\_\_\_\_