

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

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	Policy Number	
( ) - Home Telephone	( ) - Work Telephone	Carrier's Address		City	State Zip
- - Social Security Number	<input type="checkbox"/> M <input type="checkbox"/> 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.**

**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/**