

# CLAIM BY EMPLOYEE, REPRESENTATIVE, OR DEPENDENT FOR BENEFITS FOR LUNG DISEASE

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

### Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

Employee's Name _____	Social Security Number _____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	Date of Birth _____
Address _____	If Employee is deceased, list Personal Representative _____			
City _____ State _____ Zip _____	Spouse's Name _____			
( ) _____	( ) _____	Name of Attorney if represented _____		
Employee's Home Telephone _____	Work Telephone _____			

### PRINT OR TYPE ALL ANSWERS

Notice is hereby given, as required by law, that the above-named employee sustained an occupational disease caused by exposure to: cotton dust ; silica ; asbestos ; or other substance  and, if known, state substance: \_\_\_\_\_.  
Date of diagnosis \_\_\_\_\_ By: Dr. \_\_\_\_\_ Attach diagnosing medical records.  
Date of death, if applicable \_\_\_\_\_

### Employer-Defendants Attach additional pages if necessary

Employer Name: _____	Telephone: ( ) _____	Dates of Employment _____
Address: _____	Location of Job(s) _____	
City _____ State _____ Zip _____		

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Address: _____	Location of Job(s) _____	
City _____ State _____ Zip _____		

Employer Name: _____	Telephone: ( ) _____	Dates of Employment _____
Address: _____	Location of Job(s) _____	
City _____ State _____ Zip _____		

IT IS REQUIRED THAT BOTH PAGES OF THIS FORM BE COMPLETED IN ORDER TO PROCESS THIS CLAIM

E-MAIL TO: [FORMS@IC.NC.GOV](mailto:FORMS@IC.NC.GOV)  
MAIL TO: NCIC - CLAIMS SECTION

1235 MAIL SERVICE CENTER  
RALEIGH, NORTH CAROLINA 27699-1235  
MAIN TELEPHONE (919) 807-2500  
HELPLINE: (800) 688-8349  
WEBSITE: [HTTP://WWW.IC.NC.GOV/](http://www.ic.nc.gov/)

**Employment History, Beginning with Most Recent Employment (Attach additional pages if necessary):**

Employer	From / To:	Employer's Type of Business	Employee's Job Title

If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:

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Employer	From / To:	Employer's Type of Business	Employee's Job Title

If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:

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Employer	From / To:	Employer's Type of Business	Employee's Job Title

If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:

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List the names and addresses of all family physicians, treating physicians and hospitals that have provided medical services or treatment to you over a 20 year period prior to the filing of this claim.

Year	Name	Address (City)	Purpose for which treated (if known)

I hereby authorize the above named medical sources to disclose medical records (including images such as x-rays, CT scans, MRIs, sonograms, etc.) regarding my treatment, hospitalization, and/or outpatient care for any condition during the period(s) identified above to all parties (including insurance companies) or State agencies that may review my application for compensation. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for benefits under the Workers' Compensation Act.

I understand this authorization will automatically expire when my application for benefits is finally decided.

Signature of (Check One) <input type="checkbox"/> Employee, <input type="checkbox"/> Attorney, <input type="checkbox"/> Representative, or <input type="checkbox"/> Dependent	(     ) Telephone Number
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Address	City	State	Zip	Date Completed
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Employee should return original of this form to the Industrial Commission, furnish his/her employer with one signed copy and retain a copy.