

APPLICATION TO TERMINATE OR SUSPEND PAYMENT OF COMPENSATION (G.S. § 97-18.1)

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employee's Name		Email Address		Employer's Name		Email Address		Telephone Number	
Address				Employer's Address				City	State
City		State		Zip		Insurance Carrier			
Home Telephone		Work Telephone		Carrier's Address				City	State
XXX-XX-XXXX		M ☐ F ☐		/ /		Zip			
Last 4 Digits of SSN		Sex		Date of Birth		Carrier's Telephone Number		Adjuster's Name	
								Email Address	

IMPORTANT NOTICE TO EMPLOYEE: YOUR BENEFITS MAY BE STOPPED UNLESS YOU OBJECT IMMEDIATELY. IF YOU BELIEVE YOUR BENEFITS SHOULD NOT BE STOPPED, YOU MUST FILL OUT SECTION B. OF THIS FORM AND RETURN ONE COPY OF THIS FORM TO THE INDUSTRIAL COMMISSION. IF THE INDUSTRIAL COMMISSION HAS NOT RECEIVED THE COMPLETED COPY OF THIS FORM FROM YOU BY _____, YOUR BENEFITS MAY BE STOPPED WITHOUT FURTHER NOTICE TO YOU. IF YOU OBJECT, YOU MAY HAVE THE RIGHT TO AN INFORMAL HEARING BY THE INDUSTRIAL COMMISSION BEFORE YOUR BENEFITS CAN BE STOPPED. (THE DATE TO BE INSERTED ABOVE BY THE EMPLOYER OR CARRIER/ADMINISTRATOR SHALL BE AT LEAST 17 DAYS AFTER THIS APPLICATION WAS ELECTRONICALLY FILED WITH THE INDUSTRIAL COMMISSION.)

SECTION A. To Be Completed By The Employer Or Carrier/Administrator:

- Date of injury by accident: _____ Date disability began: _____
- Nature and extent of injury: _____

- Number of weeks compensation paid: _____ From: _____ To: _____
- Total amount of indemnity compensation paid to date: \$ _____
- Check applicable box(s):
 - ☐ a. An agreement was approved by the Industrial Commission on _____
 - ☐ b. The employer admitted employee's right to compensation pursuant to N.C. Gen. Stat. § 97-18(b).
 - ☐ c. The employer paid compensation to employee without contesting claim within the statutory period provided under N.C. Gen. Stat. § 97-18(d).
 - ☐ d. Other: _____
- Application is made to ☐ terminate or ☐ suspend compensation to the employee on the grounds that: _____

- Check box if employee is in managed care. ☐

ATTORNEYS FILE VIA EDFP
[HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML](https://www.ic.nc.gov/docfiling.html)

EMPLOYEE FILING OPTIONS
 E-MAIL TO: EXECSEC@IC.NC.GOV
 FAX TO: (919) 715-0282
 MAIL TO: NCIC - EXECUTIVE SECRETARY
 1236 MAIL SERVICE CENTER
 RALEIGH, NC 27699-1236

HELPLINE: (800) 688-8349
 WEBSITE: [HTTPS://WWW.IC.NC.GOV](https://www.ic.nc.gov)

In addition to filing this application and supporting documents with the Industrial Commission, I hereby certify that a copy of this application, together with all supporting documents, was served on the employee via Standard U. S. Mail, at:

(address) _____

(city, state, zip) _____

OR on the employee's attorney of record, if any, by e-mail or facsimile to:

(If e-mail, use the direct e-mail address for employee's attorney of record)

On the day of: _____ . The attached documents consist of _____ pages.
(date) (number)

SIGNATURE

PRINTED NAME

DATE

TELEPHONE NUMBER

DIRECT E-MAIL ADDRESS

TO BE COMPLETED BY THE EMPLOYEE

SECTION B. IF YOU THINK YOUR COMPENSATION SHOULD NOT BE STOPPED, YOU SHOULD COMPLETE THIS SECTION.

1. I do not think my compensation should be stopped because: _____

2. Enclose and specify the number of pages of documents the Industrial Commission should consider: _____
3. Provide a telephone number below at which you can be reached when the informal hearing is scheduled, from Monday through Friday between 8:00 a.m. and 5:00 p.m.. The Industrial Commission will notify you of the date and time of the hearing.

SIGNATURE OF EMPLOYEE OR ATTORNEY, IF REPRESENTED

PRINTED NAME

DATE

TELEPHONE NUMBER

DIRECT E-MAIL ADDRESS

If you need assistance in completing this form, you may contact the Industrial Commission at (800) 688-8349. You must contact the Office of the Executive Secretary at (919) 807-2657 to obtain an extension of time in which to submit medical records, or to obtain documents you have not been able to obtain.

EMPLOYEE: SEND A COPY YOUR RESPONSE ON THIS FORM AND SUPPORTING DOCUMENTS TO THE ATTORNEY IN SECTION A WHO FILED THIS FORM 24 APPLICATION ON BEHALF OF THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU ARE RECEIVING COMPENSATION. FILE A COPY WITH THE INDUSTRIAL COMMISSION AS INSTRUCTED AT THE BOTTOM OF THE FORM.

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