

Carrier File # _____

Employee's Name			Email Address		
Address			Employer's Name		
City			State		Zip
()			()		
Home Telephone			Work Telephone		
XXX-XX-			/ /		
Last 4 Digits of SSN			Sex		Date of Birth

Employer's Name			Email Address			()		
Address			City			State		Zip
Insurance Carrier			Carrier's Address			City		
()			State			Zip		
Carrier's Telephone Number			Adjuster's Name			Email Address		

- | | | |
|-----|--|---------------------|
| 1. | Date of accident or disability from occupational disease _____. | |
| 2. | Salary ☐ was / ☐ was not continued. | Total Dollar Amount |
| 3. | Number of weeks temporary total _____ from _____, through _____ | \$ _____ |
| | _____ from _____, through _____ | \$ _____ |
| 4. | Number of weeks temporary partial _____ from _____, through _____ | \$ _____ |
| | _____ from _____, through _____ | \$ _____ |
| 5. | Number of weeks permanent partial _____ from _____, through _____ | \$ _____ |
| 6. | Disfigurement amount paid \$ _____ | |
| 7. | Death benefits paid \$ _____ | |
| 8. | Loss of organ or body part benefits paid \$ _____ | |
| 9. | Total of lines 3 through 8, including any attorney fee paid to employee's attorney \$ _____ | |
| 10. | Compromise Settlement Agreement amount \$ _____ | |
| 11. | a. Total medical paid \$ _____ Does this include final medical? ☐ Yes / ☐ No
(Include bills for nursing, doctor, hospital, drugs, etc., but exclude rehabilitation and "medical only" paid) | |
| | b. Total rehabilitation paid \$ _____ | |
| | c. Total "medical only" paid \$ _____ | |
| 12. | Total of lines 9, 10, 11a, and 11b. \$ _____ | |
| 13. | Miscellaneous payments: | |
| | Funeral benefits \$ _____ | |
| | Second injury fund \$ _____ | |
| | Hearing Costs \$ _____ | |
| | Expert witness fees \$ _____ | |
| | Other \$ _____ | |
| | Total Miscellaneous Payments | \$ _____ |
| 14. | Has employee returned to work? ☐ Yes / ☐ No If so, on what date? _____ At what wage? _____ | |
| 15. | Date last compensation check forwarded _____ Was this the final payment? ☐ Yes / ☐ No | |
| 16. | Date last medical compensation paid _____ Was this the final payment? ☐ Yes / ☐ No | |

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

DATE _____

This form must be filed with the Industrial Commission at the address below, and a copy provided the employee with his last compensation check within 16 days following final payment of compensation and final medical payment.

WEBSITE: [HTTPS://WWW.IC.NC.GOV](https://www.ic.nc.gov)

FOR INDUSTRIAL COMMISSION USE ONLY

Days _____
Compensation Paid \$ _____
Medical \$ _____
IC Code: _____

**IMPORTANT NOTICE TO EMPLOYEE CLAIMING
ADDITIONAL WEEKLY COMPENSATION CHECKS
OR LUMP SUM PAYMENT**

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
CLAIMING ADDITIONAL MEDICAL BENEFITS
INJURED BEFORE JULY 5, 1994**

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
CLAIMING ADDITIONAL MEDICAL BENEFITS
INJURED ON OR AFTER JULY 5, 1994**

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.

DEFINITION OF MEDICAL COMPENSATION

The term "medical compensation" means medical, surgical, hospital, nursing and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, as may reasonably be required to effect a cure or give relief, and for such additional time, as in the judgment of the Industrial Commission, will tend to lessen the period of disability; and any original artificial members as may reasonably be necessary at the end of the healing period, and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. **N.C. Gen. Stat. § 97-2(19).**

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission's Information Specialists at **(800) 688-8349**

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
[HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML](https://www.ic.nc.gov/docfiling.html)

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: [HTTPS://WWW.IC.NC.GOV](https://www.ic.nc.gov)