North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

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

Employee's Name	Email Address	Employer's Name	Email Address	( ) - 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
XXX-XX- Last 4 Digits of SSN	☐ M ☐ F Sex / / Date of Birth	( ) - Carrier's Telephone Number	Adjuster's Name	Email Address	
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 or modification:

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.

FORM 62

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
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