North Carolina Industrial Commission

IC File #_____

REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF COMPENSATION AND MEDICAL COMPENSATION PAID PURSUANT TO A COMPROMISE SETTLEMENT AGREEMENT

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

THIS FORM IS ONLY TO BE USED IN SETTLED CASES

Employee's Name | Email Address

Address

City | State | Zip

( ) Home Telephone | ( ) Work Telephone

XXX-XX- Last 4 Digits of SSN | ☐ M ☐ F Sex | / / Date of Birth

Employer's Name | Email Address | ( ) Telephone Number

Employer's 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. Loss of organ or body part benefits paid $_____
8. TOTAL OF LINES 3 THROUGH 7 $_____
9. Compromise Settlement Agreement amount $_____
10. Total Medical Paid $_____

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

SIGNATURE | TITLE | DATE

This form must be filed with the Industrial Commission at the address below.

FOR INDUSTRIAL COMMISSION USE ONLY	
Days	_____
Compensation Paid	$_____
Medical	$_____
IC Code:	_____

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML

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CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTPS://WWW.IC.NC.GOV