North Carolina Industrial Commission

AGREEMENT FOR COMPENSATION FOR DISABILITY

(G.S. § 97-82)

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

IC File # ________________
Emp. Code # ________________
Carrier Code # ________________
Carrier File # ________________
Employer FEIN ________________

Employee's Name ________________
Address ________________
City ________ State ________ Zip ________
( ) Home Telephone ________ ( ) Work Telephone ________
XXX-XX- Last 4 Digits of SSN ☐ M ☐ F Sex / / Date of Birth

Employer's Name ________ ( ) Telephone Number ________
Employer's Address ________ City ________ State ________ Zip ________
Insurance Carrier ________________
Carrier's Address ________ City ________ State ________ Zip ________
( ) Carrier's Telephone Number ________ ( ) Fax Number ________

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and ________________ is the carrier/administrator for the employer.
2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on or by ________________.
3. The injury by accident or occupational disease resulted in the following injuries: ________________
4. The employee ☐ was/ ☐ was not paid for the entire day when the injury occurred.
5. The average weekly wage of the employee at the time of the injury, **including overtime and all allowances**, was $ ________________, subject to verification unless otherwise agreed upon in line 9 below.
6. Disability resulting from the injury or occupational disease began on ________________.
7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $ ________ per week beginning ________________, and continuing for ________________ weeks.
8. The employee ☐ has / ☐ has not returned to work for ________________ on ________________, at an average weekly wage of $ ________________.
9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: ________________
10. If applicable, the Second Injury Fund Assessment is $ ________________. Check ☐ is ☐ is not attached.
11. The date of this agreement is ________________. Date of first payment: ________________ Amount: ________________

Name Of Employer ________ Signature ________ Title ________

Name Of Carrier / Administrator ________ Signature ________ Title ________

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form.

Signature of Employee ________ Address ________

Signature of Employee's Attorney ________ Address ________

☐ CHECK BOX IF NO ATTORNEY RETAINED.

☐ CHECK BOX IF EMPLOYEE IS IN MANAGED CARE.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

____
CLAIMS EXAMINER **DATE**

____
ATTORNEY'S FEE APPROVED

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IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, 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 INJURED BEFORE JULY 5,1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

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

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, *Employee's Application for Additional Medical Compensation* (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

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

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