1	11 NCAC 23L .0101 is amended with changes as published in 34:20 NCR 1853-58 as follows:
2	
3	11 NCAC 23L .0101 FORM 21 – AGREEMENT FOR COMPENSATION FOR DISABILITY
4	(a)(Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21,
5	Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation
6	therefor pursuant to G.S. 97 29 and 97 30. Additional issues agreed upon by the parties such as payment of
7	compensation for permanent partial disability may also be included on the form. This form is necessary to comply
8	with Rule 11 NCAC 23A .0501, where applicable. The Form 21, Agreement for Compensation for Disability, shall
9	read as follows:
10	
11	North Carolina Industrial Commission
12	Agreement for Compensation for Disability
13	(G.S. 97-82)
14	
15	IC File#
16	Emp. Code #
17	Carrier Code #
8	Carrier File #
9	Employer FEIN
1 2	The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act
3 4 5	Employee's Name
6 7	Address
8	City State Zip
9 0	Home Telephone Work Telephone
l	Social Security Number: Sex:
2	
4	Employer's Name Telephone Number
5 5	Employer's Address City State Zip
7	Insurance Carrier
))	Carrier's Address City State Zip
	Carrier's Telephone Number Carrier's Fax Number
3	
1	We, The Undersigned, Do Hereby Agree And Stipulate As Follows:
5	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. The ampleyee systemed on injury by assident or the employee contracted an ecouncitional disease origins out
	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	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.
	1 V J V

1 of 6

5. The average weekly wage of the emplo		iem y neiow.	
was \$, subject to verification unless of 6. Disability resulting from the injury or o			
 Disability resulting from the injury or o The employer and carrier/administrator 			a amployee at the
			i e empioyee at the
\$ per week beginning, and c 8. The employee ☐ has / ☐ has not return		weeks.	
* *			
on, at an average weekly wa 9. State any further matters agreed upon		nt narmonant nort	inl or temporary
disability:	i, including distiguicine	in, permanent part	iai, or temporary
10. If applicable, the Second Injury Fund A	ssessment is \$	Check □ is □ is n	ot attached
11. The date of this agreement is	Date of first novment:	. Check - is - is is	
12. IMPORTANT NOTICE TO EMPLOY			
is \$300.00 to be paid in equal shares by the emp			
the fee in advance, and if your award is \$3,000.			
award is more than \$3,000.00, the employer sha			
agree otherwise.	un deduct \$150.00 from	your awara, ames.	, you und your on
Check one of the boxes below if the award is mo	re than \$3,000,00:		
☐ The employer will deduct \$150.00 from the as		nt to this agreement	<u>+</u>
The employee and employer have agreed that			
The employee and employer have agreed that	the employer win pay th	ic chime icc.	
Name Of Employer	Signature	Title	
- Compression	Signature	11010	
Name Of Carrier / Administrator	Signature	Title	
Tunio of Curror / Hammistator	Signature	1100	
By signing I enter into this agreement and certing Pages 1 and 2 of this form.		Important Notices	to Employee" pri
	fy that I have read the "Address	Important Notices	to Employee" prii
Pages 1 and 2 of this form. Signature of Employee	Address	Important Notices	to Employee" prii
Pages 1 and 2 of this form.		Important Notices	to Employee" prii
Pages 1 and 2 of this form. Signature of Employee	Address	Important Notices	to Employee" prii
Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission	Address	Important Notices	to Employee" prii
Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney	Address	Important Notices	to Employee" prii
Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission	Address Address	Important Notices	to Employee" prid
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Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved: Claims Examiner Dat	Address Address	Important Notices	to Employee" prii
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Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved: Claims Examiner Dat Attorney's Fee Approved □ Check Box If No Attorney Retained. □ Check Box If Employee Is In Managed Care.	Address		
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Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved: Claims Examiner Dat Attorney's Fee Approved □ Check Box If No Attorney Retained. □ Check Box If Employee Is In Managed Care. IMPORTANT NOTICE TO EMPLOYEE CL PAYMENTS	Address Address Address	L WEEKLY CHE	ECKS OR LUMP
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Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved: Claims Examiner Dat Attorney's Fee Approved Cheek Box If No Attorney Retained. Cheek Box If Employee Is In Managed Care. IMPORTANT NOTICE TO EMPLOYEE CL PAYMENTS Once your compensation checks have been stopp Commission in writing within two years from the these benefits may be lost. IMPORTANT NOTICE TO EMPLOYEE IN	Address Address Address Address Address Address Address	L WEEKLY CHE	ECKS OR LUMP must notify the Inc n check or your ri
Pages 1 and 2 of this form. Signature of Employee Signature of Employee's Attorney North Carolina Industrial Commission The Foregoing Agreement Is Hereby Approved: Claims Examiner Dat Attorney's Fee Approved □ Check Box If No Attorney Retained. □ Check Box If Employee Is In Managed Care. IMPORTANT NOTICE TO EMPLOYEE CL PAYMENTS Once your compensation checks have been stopp Commission in writing within two years from these benefits may be lost.	Address Address Address Address Address Address Address	L WEEKLY CHE	ECKS OR LUMP must notify the Inc n check or your ri

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably 1 2 necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission. 3 4 IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL 5 **MEDICAL BENEFITS** 6 If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several 7 factors. Your right to payment of future medical compensation will terminate two years after your employer or 8 earrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think 9 you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, 10 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.ie.ne.gov/forms.html. 11 12 13 **IMPORTANT NOTICE TO EMPLOYER** 14 15 16 The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 17 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or 18 earrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the 19 agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical 20 Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty. 21 22 **NEED ASSISTANCE?** 23 24 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at 25 (800) 688 8349. 26 27 Form 21 11/2014 28 29 30 Self Insured Employer or Carrier, Mail to: NCIC Claims Section 31 4335 Mail Service Center 32 33 Raleigh, NC 27699 4335 34 Telephone: (919) 807-2502 35 Helpline: (800) 688-8349 36 Website: http://www.ic.nc.gov/ 37 38 (a) (Effective July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21, Agreement 39 for Compensation for Disability, for agreements regarding disability and payment of compensation therefor pursuant 40 to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent 41 partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, 42 where applicable. The Form 21, Agreement for Compensation for Disability, shall read as follows: 43 44 North Carolina Industrial Commission 45 Agreement for Compensation for Disability (G.S. 97-82) 46 47 48 IC File # 49 Emp. Code # 50 Carrier Code # 51 Carrier File # 52 Employer FEIN

Employee's Name		
Address		_
City State	Zip	_
Home Telephone	Work Telephone	_
Last 4 digits of Social Security Num	ber: Sex: 🗆 M 🗖 F 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	Carrier's Fax Numb	er
is the carrier/administra		
2. The employee sustained an	injury by accident or the employee coon or by ccupational disease resulted in the followers.	
2. The employee sustained and of and in the course of employment of 3. The injury by accident or of 4. The employee □ was/□ was \$ the average weekly wage of was \$ the subject to verification.	injury by accident or the employee comon or by coupational disease resulted in the follows not paid for the entire day when the of the employee at the time of the injury on unless otherwise agreed upon in It	llowing injuries: ne injury occurred. ury, including overtime and all allotem 9 below.
2. The employee sustained an of and in the course of employment of 3. The injury by accident or or 4. The employee □ was/□ was 5. The average weekly wage of was \$, subject to verification 6. Disability resulting from the 7. The employer and carrier/accidents	injury by accident or the employee coon or by coupational disease resulted in the folgas not paid for the entire day when the of the employee at the time of the injoin unless otherwise agreed upon in It is injury or occupational disease began diministrator hereby undertake to pay	llowing injuries: ne injury occurred. ury, including overtime and all allo tem 9 below. n on compensation to the employee at th
2. The employee sustained and of and in the course of employment of 3. The injury by accident or or 4. 4. The employee □ was/□ was/ 5. The average weekly wage of was \$, subject to verification for the course of the employer and carrier/accept was \$ per week beginning the course of the employee □ has / □	injury by accident or the employee comon or by coupational disease resulted in the follows as not paid for the entire day when the of the employee at the time of the injury on unless otherwise agreed upon in It is injury or occupational disease began diministrator hereby undertake to pay, and continuing for, as not returned to work for	llowing injuries: ne injury occurred. ury, including overtime and all allower below. n on compensation to the employee at the weeks.
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1	North Carolina Industrial Commission	
2	The Foregoing Agreement Is Hereby A	approved:
3		
4	Claims Examiner	Date
5		
6	Attorney's Fee Approved	
7		
8	☐ Check Box If No Attorney Retained	l .
9	☐ Check Box If Employee Is In Manager	ged Care.
10		_

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 file an application for additional medical compensation pursuant to G.S. 97-25.1 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.ie.ne.gov/forms.html. An application for additional medical compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy of the form 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. 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.

- 52 Form 21
- 53 7/2015 [8/2020] 3/2021

- 55 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"): Carrier, Mail to:
- 56 NCIC Claims Section

1 4335 Mail Service Center 2 Raleigh, NC 27699-4335 3 Telephone: (919) 807-2502 4 Helpline: (800) 688-8349 5 Website: http://www.ic.nc.gov/ 6 https://www.ic.nc.gov/docfiling.html 7 **Contact Information:** 8 NCIC- Claims Administration 9 Telephone: (919) 807-2502 10 Helpline: (800) 688-8349 11 Website: https://www.ic.nc.gov The copy of the form described in Paragraph (a) of this Rule can be accessed at 12 (b) 13 http://www.ic.nc.gov/forms/form21.pdf. https://www.ic.nc.gov/forms/form21.pdf. The form may be reproduced only 14 in the format available at http://www.ic.ne.gov/forms/form21.pdf https://www.ic.nc.gov/forms/form21.pdf and may 15 not be altered or amended in any way. 16 17 History Note: Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77; 18 *Eff. November 1, 2014;*

Recodified from 04 NCAC 10L .0101 Eff. June 1, 2018;

Amended Eff. March 1, 2021.

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1 11 NCAC 23L .0102 is amended with changes as published in 34:20 NCR 1858-62 as follows: 2 3 11 NCAC 23L .0102 FORM 26 - SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF 4 **COMPENSATION** 5 (a)(Effective until July 1, 2015) If the parties to a workers' compensation claim have previously entered into an 6 approved agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement 7 8 as to Payment of Compensation, for agreements regarding subsequent additional disability and payment of 9 compensation pursuant to G.S. 97 29 and 97 30. Additional issues agreed upon by the parties such as payment of 10 compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of 11 12 Compensation, shall read as follows: 13 14 North Carolina Industrial Commission Supplemental Agreement as to Payment 15 16 of Compensation (G.S. §97-82) 17 IC File# 18 19 Emp. Code # 20 Carrier Code # Carrier File # 21 22 Employer FEIN 23 24 The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act 25 26 27 Employee's Name 28 29 Address 30 31 State City-Zip 32 33 Home Telephone Work Telephone Social Security Number: Sex: \(\pi\) M \(\phi\) F Date of Birth: 34 35 36 37 Employer's Name Telephone Number 38 39 Employer's Address City State 40 41 Insurance Carrier 42 43 Carrier's Address City State Zip 44 45 Carrier's Telephone Number Carrier's Fax Number 46 47 We, The Undersigned, Do Hereby Agree and Stipulate As Follows: 48 Date of injury: _____

1 of 6

Employee's average weekly wage was reduced / was increased on	3. The emp				
per week. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the per week. The molecular per week. The type of disability compensation is per week. State any further matters agreed upon, including disfigurement or temporary partial disability. IMPORTANT NOTICE TO EMPLOYEE. The Industrial Commission's fee for processing this agree \$500.00 to be paid in equal shares by the employee and the employer. You are not required to pay your por the fee in advance, and if your award is \$5,000.00 or less, you are not required to pay your por the fee in dance, and if your award is \$5,000.00 or less, you are not required to pay your por the fee in dance, and if your award is 5,000.00 or less, you are not required to pay your por the fee in advance, and if your award is 5,000.00 or less, you are not required to pay your por the fee in advance, and if your award is 5,000.00 or less, you are not required to pay your por the fee in advance, and if your award is 5,000.00 or less, you are not responsible for any portion of the fee. The december of the boxes below if the award is more than \$5,000.00 or my your award, unless you and your emgree otherwise. The date of this agreement is					
The employer and carrier/administrator hereby undertake to pay compensation to the employee at the stage per week. Deginning and continuing for weeks. The type of disability compensation is a many further matters agreed upon, including disfigurement or temporary partial disability. The important NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agree \$300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your por he fee in advance, and if your award is \$3,000.00 or less, you are not responsible for any portion of the fee. I was a fee in advance, and if your award is \$3,000.00 or less, you are not responsible for any portion of the fee. I was a fee in advance, and if you and your employer shall deduct \$150.00 from your award, unless you and your empression of the boxes below if the award is more than \$3,000.00. The employer will deduct \$150.00 from the amount to be paid pursuant to this agreement. The amployer will deduct \$150.00 from the amount to be paid pursuant to this agreement. The amployer are made and the employer will pay the entire fee. The date of this agreement is Name Of Employer Signature Title Title Sy signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printages I and 2 of this form. Signature of Employee's Attorney Address Check box if no attorney retained. North Carolina Industrial Commission The Toregoing Agreement is Hereby Approved: Claims Examiner Date MPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP AAYMENTS Dee your compensation checks have been stopped, if you claim further compensation, you must notify the lad commission in writing within two years from the date of receipt of your last compensation check or your rights be lost. MPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL BENEFITS Tyour injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reas recessary, related	 Employe 	e's average weekly wage l		ased on, from \$	
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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 earrier/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.

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IMPORTANT NOTICE TO EMPLOYER

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This form shall be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form 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.

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NEED ASSISTANCE?

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

22 23 24

Form 26 11/2014

25 26 27

- Self-Insured Employer or Carrier Mail to:
- 28 NCIC Claims Administration
- 29 4335 Mail Service Center
- 30 Raleigh, North Carolina 27699 4335
- Main Telephone: (919) 807-2500 31
- Helpline: (800) 688-8349 32

33 34

Website: http://www.ic.nc.gov/

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41 42 (a) (Effective July 1, 2015) If the parties to a workers' compensation claim have previously entered into an approved agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement as to Payment of Compensation, for agreements regarding subsequent additional disability and payment of compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of Compensation, shall read as follows:

43 44 45

- North Carolina Industrial Commission
- 46 Supplemental Agreement as to Payment
- 47 of Compensation (G.S. §97-82)

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49 IC File # Emp. Code # _____ 50 Carrier Code # _____ 51 52 Carrier File # 53 Employer FEIN

54 55

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

Address				
144100				-
City State Zip				-
Home Telephone	Wo	rk Teler	ohone	-
Last 4 digits of Social Security Number:				of Birth:
Employer's Name	Telephor	ne Niimh	ner	-
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Employer's Address	City	State	Zip	
Insurance Carrier				-
Carrier's Address	City	State	Zip	-
Carrier's Telephone Number	Car	rier's Fa	x Numbe	- r
We, The Undersigned, Do Hereby Agree and S	Stipulate A	s Follov	vs:	
 Date of injury: The employee □ returned to work / □ The employee became totally disabled Employee's average weekly wage □ 	was rated	l on		(date), at a weekly wage of \$
3. The employee became totally disabled	d on			
	was reduc	ed / 🗖	was incr	eased on, from \$
per week to \$ per week.		. 1 4 1		
5. The employer and carrier/administrate	or hereby i	indertak	e to pay c	compensation to the employee at
\$ per week. Beginning, and continuing for	,	veeks '	The type	of disability compensation is
beginning, and continuing for		weeks.	The type (or disability compensation is
6. State any further matters agreed upon	, including	disfigu		temporary partial disability:
		, aisiiga	rement or	temporary partial disability.
7 The date of this agreement is			rement or	·
7. The date of this agreement is	·		rement or	· .
7. The date of this agreement is Name Of Employer		gnature		Title
Name Of Employer	Si	gnature		Title
Name Of Employer	Si			·
Name Of Employer Name Of Carrier/Administrator	Si Sig	gnature		Title
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Name Of Employer Name Of Carrier/Administrator By signing I enter into this agreement and cer Page 2 of this form. Signature of Employee Signature of Employee's Attorney Check box if no attorney retained.	Si Sig rtify that I	gnature gnature have re	ad the "Ir	Title
Name Of Employer Name Of Carrier/Administrator By signing I enter into this agreement and cer Page 2 of this form. Signature of Employee Signature of Employee's Attorney	Si Sig rtify that I Ad	gnature gnature have re	ad the "Ir	Title
Name Of Employer Name Of Carrier/Administrator By signing I enter into this agreement and cer Page 2 of this form. Signature of Employee Signature of Employee's Attorney Check box if no attorney retained. North Carolina Industrial Commission	Si Sig rtify that I Ad	gnature gnature have re	ad the "Ir	Title

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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 file an application for additional medical compensation pursuant to G.S. 97-25.1 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. An application for additional medical compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

This form shall be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form 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. 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.

43 Form 26

44 7/2015[8/2020] 3/2021

- Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"): Carrier Mail to:
- 47 NCIC Claims Administration
- 48 4335 Mail Service Center
- 49 Raleigh, North Carolina 27699 4335
- 50 Main Telephone: (919) 807-2500
- 51 Helpline: (800) 688-8349
- 52 Website: http://www.ic.nc.gov/
- 53 https://www.ic.nc.gov/docfiling.html
- 54 <u>Contact Information:</u>
- 55 NCIC- Claims Administration
- 56 Telephone: (919) 807-2502

1	<u> Helpline: (800)</u>	<u>688-8349</u>
2	Website: https:/	//www.ic.nc.gov
3		
4	(b) The c	opy of the form described in Paragraph (a) of this Rule can be accessed at
5	http://www.ic.n	c.gov/forms/form26.pdf. https://www.ic.nc.gov/forms/form26.pdf. The form may be reproduced only
6	in the format a	vailable at http://www.ic.nc.gov/forms/form26.pdf https://www.ic.nc.gov/forms/form26.pdf and may
7	not be altered o	r amended in any way.
8		
9	History Note:	Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;
10		Eff. November 1, 2014;
11		Recodified from 04 NCAC 10L .0102 Eff. June 1, 2018;
12		Amended Eff. March 1, 2021.

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11 NCAC 23L .0103 is amended with changes as published in 34:20 NCR 1862-67 as follows: 1 2 3 11 NCAC 23L .0103 FORM 26A - EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO 4 PERMANENT PARTIAL DISABILITY 5 (a) (Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's 6 7 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97 31. 8 Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to 9 G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall read as 10 11 follows: 12 13 North Carolina Industrial Commission 14 Employer's Admission of Employee's Right to Permanent Partial Disability 15 (G.S. §97-31) 16 17 IC File# Emp. Code # 18 Carrier Code # 19 20 Carrier File # 21 Employer FEIN 22 23 The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act 24 25 26 Employee's Name 27 28 **Address** 29 Zip 30 City State 31 32 Work Telephone Home Telephone 33 Social Security Number: 34 35 36 Employer's Name Telephone Number 37 38 Employer's Address City State 39 40 Insurance Carrier 41 Carrier's Address 42 City State Zip 43 44 Carrier's Telephone Number Carrier's Fax Number 45 WE. THE UNDERSIGNED. DO HEREBY AGREE AND STIPULATE AS FOLLOWS: 46 47 1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and 48 is the Carrier/Administrator for the Employer. 49 2. The employee sustained an injury by accident or the employee contracted an occupational disease arising 50 out of and in the course of employment on

	arolina Industrial Comr egoing Agreement Is He				
Nouth C	avoling Industrial Com	niccion			
II Chec	k box if no attorney reta	ined.			
Ü	re of Employee's Attorne		Address		Date
Signatur	e of Employee		Address		Date
	ng I enter into this agree on pages 2 and 3 of this		at I have read the "I	mportant Notice	es to Employee"
Name O	f Carrier/Administrator	Signature	Direct Phone	e Number T	itle Date
Name O	f Employer	Signature		Title	
	ration pursuant to G.S. S			jeved weit till	- Liwish two Commission
	lersigned hereby certify I to the employee or t				
∏ The e ∏ The e	mployer will deduct \$15 mployee and employer i	50.00 from the amou have agreed that the	nt to be paid pursua employer will pay t	he entire fee.	
otherwis Check o	se. ne of the boxes below if	the award is more th	han \$3,000.00:		
_	than \$3,000.00, the emp	ployer shall deduct	\$150.00 from your	award, unless y	ou and your employer
fee in ad	lvance, and if your awar	d is \$3,000.00 or less	s, you are not respor	isible for any po	rtion of the fee. If your
	IMPORTANT NOTICE to be paid in equal share				
	included.				nuo aggina this sa
D no H.	-If applicable, the Seco	ond Injury Fund Ass	sessment is \$		A check 🖯 is 🗗
	ayment claimed, a Form	28B, Report of Con	pensation and Mea	lical Compensat	ion Paid, is attached.
	follows:				
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<u>9. </u>	State any further matte disability,				
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	amount of permane				
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	Permanent partial disa				
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	on				
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5	The average weekly wa				
_	If not, was salary conti	nuca: 	was empiovee paia	tor the date of t	njury: 🗀 yes 🗀 no

1 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.

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IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

11 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.

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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 18M, Employee's Application for Additional Medical Compensation (G.S. 97 25.1), available at http://www.ic.nc.gov/forms.html.

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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.

32 33 34

Form 26A

35 11/2014

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- Self Insured Employer or Carrier Mail to:
- 38 NCIC Claims Administration
- 39 4335 Mail Service Center
- 40 Raleigh, North Carolina 27699 4335
- 41 *Main Telephone: (919) 807-2500*
- 42 *Helpline:* (800) 688-8349
- 43 Website: http://www.ic.nc.gov/

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- 45 (a) (Effective July 1, 2015) The parties to a workers' compensation claim shall use the following Form 26A,
- 46 Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's
- 47 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31.
- 48 Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to
- 49 G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501,
- 50 where applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall
- read as follows:

Employer's Admis	dustrial Commissic ssion of Employee'		Permanent	Partial	Disabili	ty			
(G.S. §97-31)		_							
IC File #									
Emp. Code #									
Carrier Code #									
Carrier File #									
Employer FEIN _									
The Use Of This F	Form Is Required U	Jnder The	Provisions	of The	Workers	s' Compe	nsation A	Act	
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Employee's Name									
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msurance carrier									
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Carrier's Telephon	ie Number		Carr	ier's Fa	x Numb	er			
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	injury, have been provision for consideration				een filed with the
Name Of Employ	yer	Signature	Title	Dat	e
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orinted on Page 3		nd certify that I hav	e read the Important	reduces to Employ	
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Signature of Emp	oloyee's Attorney	Addr	ess	Email Address	Date
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1 Compensation (G.S. 97 25.1), available at http://www.ic.ne.gov/forms.html. An application for additional medical 2 compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by 3 written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission 4 5 forms are available at https://www.ic.nc.gov/forms.html. 6 7 IMPORTANT NOTICE TO EMPLOYER 8 The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 9 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or 10 carrier/administrator must submit the agreement to the Industrial Commission. Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and 11 Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a 12 13 penalty. 14 15 NEED ASSISTANCE? 16 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at 17 (800) 688-8349. 18 19 Form 26A 20 7/2015 6/2020[8/2020]3/2021 21 22 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"): Carrier Mail to: NCIC - Claims Administration 23 24 4335 Mail Service Center 25 Raleigh, North Carolina 27699 4335 Main Telephone: (919) 807-2500 26 Helpline: (800) 688-8349 27 Website: http://www.ic.nc.gov/ 28 29 https://www.ic.nc.gov/docfiling.html 30 Contact Information: 31 NCIC- Claims Administration Telephone: (919) 807-2502 32 Helpline: (800) 688-8349 33 34 Website: https://www.ic.nc.gov 35 36 (b) A copy of the form described in Paragraph (a) of this Rule can be accessed at 37 http://www.ic.nc.gov/forms/form26a.pdf. https://www.ic.nc.gov/forms/form26a.pdf. The form may be reproduced only in the format available at http://www.ie.ne.gov/forms/form26a.pdf https://www.ic.nc.gov/forms/form26a.pdf and 38 39 may not be altered or amended in any way. 40 41 History Note: Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77; 42 Eff. November 1, 2014;

Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;

Amended Eff. December 1, 2020;

Amended Eff. March 1, 2021.

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43 44