11 NCAC 23A .0409 is amended with changes as published in 34:14 NCR 1291-92 as follows:

11 NCAC 23A .0409 CLAIMS FOR DEATH BENEFITS

(a) An employer shall notify the Commission of the occurrence of a death resulting from an injury or occupational disease allegedly arising out of and in the course of employment by filing a Form 19 Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission within five days of knowledge ~~thereof.~~ of the death. ~~In addition, an employer, carrier, or administrator shall file with the Commission a Form 29 Supplemental Report for Fatal Accidents, within 45 days of knowledge of a death or allegation of death resulting from an injury or occupational disease arising out of and in the course of employment.~~

(b) An employer, carrier, or administrator shall ~~make a good faith effort to discover~~ conduct an investigation to determine the names and addresses of decedent's potential beneficiaries under G.S. 97-38 and identify them on the Form 29 Supplemental Report for Fatal ~~Accident.~~ Accidents. The Form 29 Supplemental Report for Fatal Accidents shall be filed with the Commission within 45 days of notification of a death or allegation of death resulting from an injury or occupational disease arising out of and in the course of employment.

(c) If the employer, carrier, or administrator disputes that an employee's death is compensable or denies it has liability for the claim, the employer, carrier, or administrator shall notify the Commission on a Form 61 Denial of Workers' Compensation Claim. When the employer, carrier, or administrator denies liability for a claim involving an employee's death, the employer, carrier, or administrator shall send the form to all known potential beneficiaries, their attorneys of record, if any, all health care providers that have submitted bills to the employer, carrier, or administrator, and the Commission.

(d) If the employer, carrier, or administrator accepts liability for a claim involving an employee's death and there are no issues necessitating a hearing for determination of beneficiaries or their respective rights, the parties shall submit either a Form 30 Agreement for Compensation for Death as set forth in Rule .0501 of this Subchapter or a proposed Opinion and Award.

(e) If the parties submit a Form 30 Agreement for Compensation for Death, the agreement shall be filed in accordance with Rule .0108 of this Subchapter with the following:

(1) a stipulation as to average weekly wage;

(2) any affidavits regarding dependents;

(3) the employee's death certificate;

(4) a Form 29 Supplemental Report for Fatal Accidents;

(5) a Form 42 Application for Appointment of Guardian ad Litem, if any beneficiary is a minor or incompetent;

(6) proof of beneficiary status, such as marriage license, birth certificate, or divorce decree;

(7) a funeral bill or stipulation as to payment of the funeral benefit;

(8) a Form 30D Award Approving Agreement for Compensation for Death; and

(9) an affidavit or itemized statement in support of an award of attorney's fees if an attorney is seeking fees for representation of one or more beneficiaries.

(f) If the parties seek a written Opinion and Award from the Commission regarding the payment of death benefits in lieu of submitting a Form 30 Agreement for Compensation for Death, the parties shall file, in accordance with Rule .0108 of this Subchapter, a proposed Opinion and Award with the following:

(1) a stipulation regarding all jurisdictional matters;

(2) the decedent's name, social security number, employer, insurance carrier or servicing agent, and the date of the injury giving rise to this claim;

(3) a stipulation as to average weekly wage;

(4) any affidavits regarding dependents;

(5) the employee's death certificate;

(6) a Form 29 Supplemental Report for Fatal Accidents;

(7) a Form 42 Application for Appointment of Guardian ad Litem, if any beneficiary is a minor or incompetent;

(8) proof of beneficiary status, such as marriage license, birth certificate, or divorce decree;

(9) medical records, if any;

(10) a statement of payment of medical expenses incurred, if any;

(11) a funeral bill or stipulation as to payment of the funeral benefit; and

(12) an affidavit or itemized statement in support of an award of attorney's fees if an attorney is seeking fees for representation of one or more beneficiaries.

(g) If an issue exists as to whether a person is a beneficiary pursuant to G.S. 97-38 or if any other disputed issue exists in an accepted claim, the employer, carrier, administrator, potential beneficiary, or any person asserting a claim for benefits may request a hearing by filing a Form 33 Request that Claim be Assigned for Hearing in accordance with Rule .0602 of this Subchapter.

(h) Upon approval by the Commission of a Form 30 Agreement for Compensation for Death or upon the issuance of a final order of the Commission directing payment of death benefits pursuant to G.S. 97-38, payment shall be made by the employer, carrier, or administrator directly to the beneficiaries, with the following exceptions:

(1) any applicable award of attorney's fees shall be paid directly to the attorney; and

(2) benefits due to a minor or incompetent.

(i) In all cases involving minors and incompetent persons who are potential beneficiaries, a guardian ad litem shall be appointed pursuant to Rule .0604 of this Subchapter.

(j) Any benefits due to a minor pursuant to G.S. 97-38 shall be paid directly to the minor's parent, legal guardian, or legal custodian, if the minor remains in the physical custody of such person, or another person if ordered by the Commission for good cause ~~[shown,]~~shown. The benefits shall be for the exclusive use and benefit of the minor. When a beneficiary reaches the age of 18, any remaining benefits shall be paid directly to the beneficiary.

(k) The Commission shall order that the benefits for an incompetent beneficiary shall be paid to the person or entity authorized to receive funds on behalf of the beneficiary pursuant to a federal or state court order, or to the Clerk of Court in the county in which the beneficiary resides, for the beneficiary's exclusive use and benefit.

(l) Upon a change in circumstances, any interested party may request that the Commission amend the terms of any award with respect to a minor or incompetent person to direct payment to another party on behalf of the minor or incompetent person.

(m) In the case of benefits commuted to present value, only those sums that have not accrued at the time of the approval of a Form 30 Agreement for Compensation for Death or entry of a final order of the Commission directing payment of death benefits pursuant to G.S. 97-38 are subject to commutation pursuant to Rule .0406 of this Subchapter.

~~(c) In all cases involving minors or incompetents who are potential beneficiaries, a guardian ad litem shall be appointed pursuant to Rule .0604 of this Subchapter.~~

~~(d) If an issue exists as to whether a person is a beneficiary under G.S. 97-38, the employer, carrier, administrator, or any person asserting a claim for benefits may file a Form 33 Request that Claim be Assigned for Hearing for a determination by a Deputy Commissioner.~~

~~(e) If the employer, carrier, or administrator accepts liability for a claim involving an employee's death and there are no issues necessitating a hearing for determination of beneficiaries or their respective rights, the parties shall submit an agreement executed by all interested parties or their representatives to the Commission. All agreements shall be submitted to the Commission on a Form 30 Agreement for Compensation for Death as set forth in Rule .0501 of this Subchapter.~~

~~(f) The agreement shall be submitted along with all relevant supporting documents, including death certificate of the employee, any relevant marriage certificate and birth certificates for any dependents.~~

~~(g) If the employer, carrier, or administrator denies liability for a claim involving an employee's death, the employer, carrier, or administrator shall send a letter of denial to all potential beneficiaries, their attorneys of record, if any, all known health care providers that have submitted bills to the employer, carrier, or administrator, and the Commission. The denial letter shall state the reasons for the denial and shall further advise of a right to hearing.~~

~~(h) Any potential beneficiary, the employer, the carrier, or the administrator may request a hearing as provided in Rule .0602 of this Subchapter.~~

~~(i) Upon approval by the Commission of a Form 30 Agreement for Compensation for Death, or the issuance of a final order of the Commission directing payment of death benefits pursuant to G.S. 97-38, payment shall be made by the employer, carrier, or administrator directly to the beneficiaries, with the following exceptions:~~

~~(1) any applicable award of attorney fees shall be paid directly to the attorney; and~~

~~(2) benefits due to a minor or incompetent.~~

~~(j) Any benefits due to a minor pursuant to G.S. 97-38 shall be paid directly to the parent as natural guardian of the minor for the use and benefit of the minor if the minor remains in the physical custody of the parent as natural guardian. If the minor is not in the physical custody of the parent as natural guardian, payment shall be made through some other person appointed by a court of competent jurisdiction or to such other person under such terms as the Commission finds is in the best interests of the parties. When a beneficiary reaches the age of 18, any remaining benefits shall be paid directly to the beneficiary.~~

~~(k) In order to protect the interests of a beneficiary who is incompetent, the Commission shall order that benefits be paid to the beneficiary's appointed general guardian for the beneficiary's exclusive use and benefit, or to the Clerk of Court in the county in which the beneficiary resides for the beneficiary's exclusive use and benefit as determined by the Clerk of Court.~~

~~(l) Upon a change in circumstances, any interested party may request that the Commission amend the terms of any award with respect to a minor or incompetent to direct payment to another party on behalf of the minor or incompetent.~~

~~(m) In the case of benefits commuted to present value, only those sums that have not accrued at the time of the entry of the Order are subject to commutation.~~

~~(n) Where the parties seek a written opinion and award from the Commission regarding the payment of death benefits in uncontested cases in lieu of presenting testimony at a hearing before a Deputy Commissioner, the parties may make application to the Commission for a written opinion by filing a written request with the Docket Director.~~

~~(o) The parties shall file, electronically, by joint stipulation, affidavit or certified document, a proposed opinion and award or order along with the following information:~~

- ~~(1) a stipulation regarding all jurisdictional matters;~~
- ~~(2) the decedent's name, social security number, employer, insurance carrier or servicing agent, and the date of the injury giving rise to this claim;~~
- ~~(3) a Form 22 Statement of Days Worked or Earnings of Injured Employee or stipulation as to average weekly wage;~~
- ~~(4) any affidavits regarding dependents;~~
- ~~(5) the death certificate;~~
- ~~(6) a Form 29 Supplemental Report for Fatal Accidents;~~
- ~~(7) Guardian ad litem forms, if any beneficiary is a minor or incompetent;~~
- ~~(8) proof of beneficiary status, such as marriage license, birth certificate, or divorce decree;~~
- ~~(9) medical records, if any;~~
- ~~(10) a statement of payment of medical expenses incurred, if any; and~~
- ~~(11) a funeral bill or stipulation as to payment of the funeral benefit.~~

~~(p) Any attorney seeking fees for representation in an uncontested claim shall file an affidavit or itemized statement in support of an award of attorney's fees.~~

History Note: *Authority G.S. 97-38; 97-39; 97-80(a);*
Eff. June 1, 2000;
Amended Eff. November 1, 2014; January 2, 2011;
Recodified from 04 NCAC 10A .0409 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23A .0903 is amended with changes as published in 34:14 NCAC 1293-94 as follows:

11 NCAC 23A .0903 EMPLOYEE'S OBLIGATION TO REPORT EARNINGS

(a) A self-insured employer, ~~carrier~~ carrier, or third-party administrator may require the employee who has filed a claim and is receiving wage loss benefits under G.S. 97-29 or G.S. 97-30 to complete a Form 90 Report of Earnings when reasonably necessary but not more than once every six months.

(b) The Form 90 Report of Earnings shall be sent to the employee by certified mail, return receipt requested, and shall include a self-addressed stamped envelope for the return of the form. When the employee is represented by an attorney, the Form 90 Report of Earnings shall be sent only to the attorney for the employee and shall be sent by any method of transmission that provides proof of receipt, including electronic mail, facsimile, or certified [~~mail~~] mail, return receipt requested. ~~and not to the employee.~~

(c) The employee shall complete and return the Form 90 Report of Earnings within 15 days after receipt of a Form 90 Report of Earnings. If the employee fails to complete and return the Form 90 Report of Earnings within 30 days of receipt of the form, the self-insured employer, ~~carrier~~ carrier, or third-party administrator may seek ~~an order from the Executive Secretary allowing the suspension of benefits. The self insured employer, carrier or third party administrator shall not suspend benefits without Commission approval pursuant to the Workers' Compensation Act.~~ to suspend compensation being paid pursuant to G.S. 97-29 by filing a Form 24 Application to Terminate or Suspend Payment of [~~Compensation~~] Compensation, as allowed by G.S. 97-18.1 and Rule .0404 of this Subchapter. ~~If the Commission suspends benefits for failure to complete and return a Form 90 Report of Earnings, the self insured employer, carrier or third party administrator shall reinstate benefits to the employee with back payment as soon as the Form 90 Report of Earnings is submitted by the employee. If benefits are not reinstated, the employee shall submit a written request for an Order from the Executive Secretary instructing the self insured employer, carrier or third party administrator to reinstate benefits. If the employee's earnings report does not indicate continuing eligibility for partial or total disability compensation, the self insured employer, carrier or third party administrator may apply to the Commission to terminate or modify benefits by filing a Form 24 Application to Terminate or Suspend Payment of Compensation or Form 33 Request that Claim be Assigned for Hearing.~~

(d) If compensation is suspended pursuant to Paragraph (c) of this Rule and the employee subsequently completes and returns the Form 90 Report of Earnings, the self-insured employer, carrier, or third-party administrator shall reinstate payment of compensation to the employee with back payment. However, if the Form 90 Report of Earnings does not indicate continuing eligibility for disability compensation, the self-insured employer, carrier, or third-party administrator is not required to reinstate payment of compensation. If the Form 90 Report of Earnings indicates continuing eligibility for temporary partial disability compensation, the self-insured employer, carrier, or third-party administrator shall make payment of compensation pursuant to G.S. 97-30 with back payment within 14 days of receipt of documentation establishing the amount of compensation due. If payment of compensation is not reinstated following submission of the completed Form 90 Report of Earnings and the employee claims entitlement to ongoing disability compensation, the employee may seek reinstatement by filing a Form 23 Application to Reinstate Payment of Disability Compensation or Form 33 Request that Claim be Assigned for Hearing.

History Note: *Authority G.S. 97-80(a); ~~97-88.2;~~*
Eff. June 1, 2000;
Amended Eff. November 1, 2014; August 1, 2006;
Recodified from 04 NCAC 10A .0903 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23B .0104 is amended with changes as published in 34:20 NCR 1852-53 as follows:

11 NCAC 23B .0104 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE

(a) All filings to the Commission in tort claims shall be submitted electronically in accordance with this Rule. Any document transmitted to the Commission in a manner not in accordance with this Rule shall not be accepted for filing. Plaintiffs without legal representation may file all documents with the Office of the Clerk of the Commission via the Commission's Electronic Document Filing Portal ~~(EDFP),~~ ("EDFP") or by sending the documents to the Clerk of the Industrial Commission via electronic ~~mail,~~ mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.

(b) ~~Except as set forth in Paragraph (c) of this Rule, all documents shall be transmitted to the Commission via EDFP.~~ Information regarding how to ~~register for and~~ use EDFP is available at http://www.ic.nc.gov/training.html. In the event EDFP is inoperable, all documents required to be filed via EDFP shall be transmitted to the Commission via electronic mail to edfp@ic.nc.gov. Documents required to be filed via EDFP that are sent to the Commission via electronic mail when EDFP is operable shall not be accepted for filing.

~~(c) The tort claims forms and documents listed in Table 1 shall not be required to be transmitted via EDFP provided all applicable qualifying conditions are met.~~

~~Table 1: Forms and documents exempt from EDFP filing requirements and how to file them:~~

~~DOCUMENT~~	~~QUALIFYING CONDITION(S)~~	~~HOW TO FILE~~
~~Form T-1~~	~~No IC file number has been assigned~~	~~Hand delivery to the Industrial Commission's main office or by mail to 1236 Mail Service Center, Raleigh, North Carolina 27699-1236.~~
~~Form T-3~~	~~No IC file number has been assigned~~	~~Email to dockets@ic.nc.gov, hand delivery to the Industrial Commission's main office, or by mail to 1236 Mail Service Center, Raleigh, North Carolina; 27699-1236~~
~~Pre-affidavit motion under Rule 9(j)(3) of the Rules of Civil Procedure to extend the Statute of Limitations.~~	~~No IC file number has been assigned.~~	~~Hand delivery to the Industrial Commission's main office or by mail to 1236 Mail Service Center, Raleigh, North Carolina 27699-1236.~~

~~(d) A one-year waiver shall be granted to an attorney who notifies the Commission of the attorney's inability to comply with the electronic filing requirements in Paragraph (a) of this Rule due to a lack of the necessary internet technology resources. The notification shall indicate why the attorney is unable to comply with the rule and outline the attorney's plan for coming into compliance within the one year period. The notification shall be filed with the Office of the Clerk of the Commission via facsimile or U.S. Mail. This Paragraph shall expire one year from the effective date of this Rule.~~

(c)~~(e)~~ Any party may apply to the Commission for an emergency temporary waiver of the electronic filing requirement set forth in Paragraph (a) of this Rule if it is unable to comply because of temporary technical problems or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be included with any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access issues.

(d)~~(f)~~ A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via ~~EDFP or U.S. Mail.~~ EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure or applicable statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing, plaintiffs without legal representation may file all documents with the Commission as provided in Paragraph (a) of this Rule.

History Note: *Authority G.S. 143-291; ~~143-291.2;~~ 143-293; 143-297; 143-300;*
Eff. May 1, 2000;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0104 Eff. June 1, 2018;
Amended Eff. March 1, 2019;
Amended Eff. February 1, 2021.

11 NCAC 23B .0105 is amended with changes as published in 34:20 NCR 1853 as follows:

11 NCAC 23B .0105 CONTACT INFORMATION

(a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address, and mailing address.

(b) All persons or entities without legal representation who have matters pending before the Commission shall ~~advise~~ inform the Commission ~~upon~~ of any change in contact information by filing a written notice via the Commission's Electronic Document Filing Portal ("EDFP"), ~~electronic mail,~~ ~~[mail (dockets@ic.nc.gov),] [mail (contactinfo@ic.nc.gov)]~~, email to contactinfo@ic.nc.gov, facsimile, U.S. Mail, private courier service, or hand delivery.

(c) A plaintiff without legal representation who was an inmate in the North Carolina Division of Adult Corrections at the time of filing his or her tort claim, shall, within ~~thirty (30)~~ 30 days of release, provide the Commission with written notice of his or her post-release contact information in any manner authorized in Paragraph (b) of this Rule. Following the initial written notice of post-release contact information, the previously incarcerated plaintiff shall continue to ~~advise the Commission upon~~ inform the Commission of all changes in contact information in accordance with Paragraph (b) of this Rule.

(d) All attorneys of record with matters before the Commission shall inform the Commission in writing of any change in the attorney's or the represented party's contact information via ~~email to dockets@ic.nc.gov.~~ EDFP.

History Note: *Authority G.S. 143-291; 143-300;*
Eff. March 1, 2019;
Amended Eff. February 1, 2021.

11 NCAC 23B .0106 is adopted with changes as published in 34:14 NCAC 1294 as follows:

11 NCAC 23B .0106 NOTICE BY THE COMMISSION

(a) If service is provided by electronic mail, "receipt of such notice" pursuant to G.S. 143-292 and "receipt of the decision and order" of the Full Commission pursuant to G.S. 143-293 is complete one hour after it is sent by the Commission, provided that:

(1) notice sent after 5:00 p.m. shall be complete at 8:00 a.m. the following State business day; and

(2) notice sent by electronic mail that is not readable by the recipient is not complete. Within five State business days of receipt of an unreadable document, the receiving party shall notify the Commission of the unreadability of the document.

(b) If service [~~shall be~~]is provided by electronic mail, notice of orders or other documents issued pursuant to G.S. 143-296 is complete in accordance with the same provisions set forth in Paragraph (a) of this Rule.

History Note: *Authority G.S. 143-300;*
Eff. December 1, 2020.

11 NCAC 23E .0104 is amended with changes as published in 34:14 NCR 1294-95 as follows:

11 NCAC 23E .0104 SECURE LEAVE PERIODS FOR ATTORNEYS

(a) Any attorney may request one or more secure leave periods each year as provided in this Rule.

(b) For the purpose of this Paragraph only, a "secure leave period" is defined as a partial calendar week or a complete calendar week. ~~During any~~ Within a calendar year, an ~~attorney's secure leave periods pursuant to this Rule shall not exceed an aggregate of three weeks.~~ attorney is entitled to obtain secure leave periods totaling up to 15 business days for any purpose.

(c) For the purpose of this Paragraph only, a "secure leave period" is defined as a complete calendar week. Within a 24-week period surrounding the birth or adoption of an attorney's child, that attorney is entitled to have the benefit of up to 12 additional secure leave periods.

~~(c) To request a secure leave period an attorney shall file a written request, by letter or motion, containing the information required by Paragraph (d) of this Rule with the Office of the Chair within the time provided in Paragraph (e). Upon such filing, the Chair shall review the request and, if the request complies with Paragraphs (d) and (e) of this Rule, issue a letter allowing the requested secure leave period. The attorney shall not be required to appear at any trial, hearing, deposition, or other proceeding before the Commission during that secure leave period.~~

(d) To request a secure leave period, an attorney shall file a written request, by letter or motion, containing the information required by Paragraph (e) of this Rule with the Office of the Chair within the time period provided in Paragraph (f) of this Rule. Upon such filing, the Chair shall review the request. If the request is made pursuant to Paragraph (b) or Paragraph (c) of this Rule and the request complies with Paragraphs (e) and (f) of this Rule, the Chair shall issue a letter allowing the requested secure leave period. The attorney shall not be required to appear at any trial, hearing, deposition, or other proceeding before the Commission during a secure leave period that is allowed.

~~(d) The request shall contain the following information:~~

~~(1) the attorney's name, address, telephone number and state bar number;~~

~~(2) the date(s) for which secure leave is being requested;~~

~~(3) the dates of all other secure leave periods during the current calendar year that have previously been designated by the attorney pursuant to this Rule;~~

~~(4) a statement that the secure leave period is not being designated for the purpose of delaying, hindering or interfering with the timely disposition of any matter in any pending action or proceeding; and~~

~~(5) a statement that no action or proceeding in which the attorney has entered an appearance has been scheduled, tentatively set, or noticed for trial, hearing, deposition or other proceeding during the designated secure leave period.~~

(e) The request shall contain the following information:

(1) the attorney's name, mailing address, telephone number, email address, and state bar number;

(2) the date(s) for which secure leave is being requested;

(3) the dates of all other secure leave periods during the current calendar year that have previously been designated by the attorney pursuant to this Rule;

(4) a statement that the secure leave period is not being designated for the purpose of delaying, hindering, or interfering with the disposition of any matter in any pending action or proceeding;

(5) a statement that no action or proceeding in which the attorney has entered an appearance has been scheduled, tentatively set, or noticed for trial, hearing, deposition, or other proceeding during the designated secure leave period; and

(6) for secure leave requests that arise under Paragraph (c) of this Rule, the expected birth date or adoption date of the child.

~~(e) To be allowed, the request shall be filed:~~

~~(1) no later than 90 days before the beginning of the secure leave period; and~~

~~(2) before any trial, hearing, deposition or other matter has been regularly scheduled, peremptorily set or noticed for a time during the designated secure leave period.~~

~~An untimely request will be denied by letter. In the event that a party has been denied secure leave because the request was not timely filed and there are extraordinary circumstances, the attorney may file a motion requesting an exception. If the case has been scheduled for hearing before a Deputy Commissioner, the motion shall be addressed to the Deputy Commissioner. If the matter is scheduled for hearing before the Full Commission, the motion shall be addressed to the Chair of the Panel before which the hearing will be held. In all other cases, the motion should be directed to the Office of the Chair.~~

(f) The request shall be filed:

(1) no later than 90 days before the beginning of the secure leave period; and

(2) before any trial, hearing, deposition, or other matter has been scheduled, peremptorily set, or noticed for a time during the designated secure leave period.

~~(f) If, after a secure leave period has been allowed pursuant to this Rule, any trial, hearing, deposition, or other proceeding is scheduled or tentatively set for a time during the secure leave period, the attorney shall file with the Deputy Commissioner or chair of the Full Commission panel before which the matter was calendared or set, and serve on all parties, a copy of the letter allowing the secure leave period with a certificate of service attached. Upon receipt, the proceeding shall be rescheduled for a time that is not within the attorney's secure leave period.~~

(g) The Chair may, as set forth in Rule .0301 of this Subchapter, make exception to the 15-day aggregate limit set forth in Paragraph (b) of this Rule, the requirement set forth in Subparagraph (e)(5) of this Rule, and the limitations set forth in [~~Subparagraphs (f)(1) and (f)(2)~~] Paragraph (f) of this Rule. An attorney requesting that the Chair make [~~this~~] an exception under this Paragraph shall inform the Chair of all known actions or proceedings involving that attorney that are scheduled, tentatively set, or noticed for trial, hearing, deposition, or other proceeding during the requested secure leave period. The attorney also shall provide notice to all opposing parties or, if represented, opposing counsel of record in all cases subject to the jurisdiction of the Industrial Commission of the beginning and ending dates of the requested secure leave period and of all known actions or proceedings involving that attorney that are scheduled, tentatively set, or noticed for trial, hearing, deposition, or other proceeding during the requested secure leave period.

~~(g) If, after a secure leave period has been allowed pursuant to this Rule, any deposition is noticed for a time during the secure leave period, the attorney may serve on the party that noticed the deposition a copy of the letter allowing the secure leave period with a certificate of service attached, and that party shall reschedule the deposition for a time that is not within the attorney's secure leave period.~~

(h) After a secure leave period has been allowed pursuant to this Rule, if any trial, hearing, or other proceeding is scheduled or tentatively set for a time during the secure leave period, the attorney shall file with the Deputy Commissioner or Chair of the Full Commission panel before which the matter was calendared or set, and serve on all parties, a copy of the letter allowing the secure leave period with a certificate of service attached. Upon receipt, the proceeding shall be rescheduled for a time that is not within the attorney's secure leave period.

(i) After a secure leave period has been allowed pursuant to this Rule, if any deposition is noticed for a time during the secure leave period, the attorney [~~may~~] shall serve on the party that noticed the deposition a copy of the letter allowing the secure leave period with a certificate of service attached, and that party shall reschedule the deposition for a time that is not within the attorney's secure leave period.

History Note: *Authority G.S. 97-80(a);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0104 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23L .0101 is amended with changes as published in 34:20 NCR 1853-58 as follows:

11 NCAC 23L .0101 FORM 21 – AGREEMENT FOR COMPENSATION FOR DISABILITY

~~(a)(Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21, Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation therefor 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 21, Agreement for Compensation for Disability, shall read as follows:~~

~~North Carolina Industrial Commission~~
~~Agreement for Compensation for Disability~~
~~(G.S. 97-82)~~

~~IC File # _____~~
~~Emp. Code # _____~~
~~Carrier Code # _____~~
~~Carrier File # _____~~
~~Employer FEIN _____~~

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

~~_____~~
~~Employee's Name~~
~~_____~~
~~Address~~
~~_____~~
~~City State Zip~~
~~_____~~
~~Home Telephone Work Telephone~~
~~Social Security Number: _____ 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 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 Item 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: _____.
12. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.

Check one 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 employee and employer have agreed that the employer will pay the entire fee.

_____

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 Pages 1 and 2 of this form.

_____

Signature of Employee | Address

_____

Signature of Employee's Attorney | Address

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner | Date

_____

Attorney's Fee Approved

☐ Check Box If No Attorney Retained.

☐ Check Box If Employee Is In Managed Care.

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.~~

~~Form 21~~
~~11/2014~~

~~Self-Insured Employer or Carrier, Mail to:~~
~~NCIC - Claims Section~~
~~4335 Mail Service Center~~
~~Raleigh, NC 27699-4335~~
~~Telephone: (919) 807-2502~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~

(a)~~(Effective July 1, 2015)~~ The parties to a workers' compensation claim shall use the following Form 21, Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation therefor 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 21, Agreement for Compensation for Disability, shall read as follows:

North Carolina Industrial Commission
Agreement for Compensation for Disability
(G.S. 97-82)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
~~Employer FEIN _____~~

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

_____
Employee's Name

_____
Address

_____
City State Zip

_____
Home Telephone Work Telephone

Last 4 digits of Social Security Number: _____ 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 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 Item 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

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's Fee Approved

☐ Check Box If No Attorney Retained.
☐ Check Box If Employee Is In Managed Care.

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 may be made on a Form 18M Employee's 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.

Form 21
~~7/2015~~ ~~[8/2020]~~ 2/2021

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

~~4335 Mail Service Center~~
~~Raleigh, NC 27699-4335~~
~~Telephone: (919) 807-2502~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~
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

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/forms/form21.pdf.~~ https://www.ic.nc.gov/forms/form21.pdf. The form may be reproduced only in the format available at ~~http://www.ic.nc.gov/forms/form21.pdf~~ https://www.ic.nc.gov/forms/form21.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0101 Eff. June 1, 2018;
Amended Eff. February 1, 2021.

11 NCAC 23L .0102 is amended with changes as published in 34:20 NCR 1858-62 as follows:

11 NCAC 23L .0102 FORM 26 – SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION

~~(a)(Effective until 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:~~

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

~~IC File # _____~~
~~Emp. Code # _____~~
~~Carrier Code # _____~~
~~Carrier File # _____~~
~~Employer FEIN _____~~

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

~~_____~~
~~Employee's Name~~
~~_____~~
~~Address~~
~~_____~~
~~City State Zip~~
~~_____~~
~~Home Telephone Work Telephone~~
~~Social Security Number: _____ 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 Number~~

~~We, The Undersigned, Do Hereby Agree and Stipulate As Follows:~~
~~1. Date of injury: _____~~

2. The employee ☐ returned to work / ☐ was rated on _____ (date), at a weekly wage of $_____.

3. The employee became totally disabled on _____.

4. Employee's average weekly wage ☐ was reduced / ☐ was increased on _____, from $_____ per week to $_____ per week.

5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week.

Beginning _____, and continuing for_____ weeks. The type of disability compensation is _____.

6. State any further matters agreed upon, including disfigurement or temporary partial disability: _____.

7. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.

Check one 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 employee and employer have agreed that the employer will pay the entire fee.

8. The date of this agreement is _____.

_____

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 Pages 1 and 2 of this form.

_____

Signature of Employee Address

_____

Signature of Employee's Attorney Address

☐ Check box if no attorney retained.

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

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~~

~~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.~~

~~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.~~

~~Form 26~~
~~11/2014~~

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

(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:

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

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
~~Employer FEIN _____~~

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

_____

Employee's Name

_____

Address

_____

City State Zip

_____

Home Telephone Work Telephone

Last 4 digits of Social Security Number: _____ 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 Number

We, The Undersigned, Do Hereby Agree and Stipulate As Follows:

1. Date of injury: _____.
2. The employee ☐ returned to work / ☐ was rated on _____ (date), at a weekly wage of $_____.
3. The employee became totally disabled on _____.
4. Employee's average weekly wage ☐ was reduced / ☐ was increased on _____, from $_____ per week to $_____ per week.
5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week.

Beginning _____, and continuing for_____ weeks. The type of disability compensation is _____.

6. State any further matters agreed upon, including disfigurement or temporary partial disability: _____.

7. The date of this agreement is _____.

_____

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.

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

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 may be made on a Form 18M Employee's 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.

Form 26
~~7/2015~~[~~8/2020~~] 2/2021

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"):~~Carrier Mail to:~~
~~NCIC - Claims Administration~~
~~4335 Mail Service Center~~
~~Raleigh, North Carolina 27699-4335~~
~~Main Telephone: (919) 807-2500~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~
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

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/forms/form26.pdf.~~ https://www.ic.nc.gov/forms/form26.pdf. The form may be reproduced only in the format available at ~~http://www.ic.nc.gov/forms/form26.pdf~~ https://www.ic.nc.gov/forms/form26.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0102 Eff. June 1, 2018;
Amended Eff. February 1, 2021.

11 NCAC 23L .0103 is amended with changes as published in 34:14 NCR 1295-1300 as follows:

11 NCAC 23L .0103 FORM 26A – EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY

~~(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 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to 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 follows:~~

~~North Carolina Industrial Commission~~
~~Employer's Admission of Employee's Right to Permanent Partial Disability~~
~~(G.S. §97-31)~~

~~IC File # _____~~
~~Emp. Code # _____~~
~~Carrier Code # _____~~
~~Carrier File # _____~~
~~Employer FEIN _____~~

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

~~_____~~
~~Employee's Name~~
~~_____~~
~~Address~~
~~_____~~
~~City State Zip~~
~~_____~~
~~Home Telephone Work Telephone~~
~~Social Security Number: _____ 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 Number

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

1. All the 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 _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____.

4. The employee □ was □ was not paid for the 7 day waiting period.

If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.

6. The employee □ has □ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.

7. Claimant was released □ with permanent restrictions □ without permanent restrictions.

8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment: _____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows: _____.

If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. □ yes □ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.

12. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the

fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.

Check one 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 employee and employer have agreed that the employer will pay the entire fee.

The undersigned hereby certify that the material medical and vocational reports related to the injury have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

_____

Name Of Employer Signature Title Date

_____

Name Of Carrier/Administrator Signature Direct Phone Number Title Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on pages 2 and 3 of this form.

_____

Signature of Employee Address Date

_____

Signature of Employee's Attorney Address_____Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

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 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.~~

~~Form 26A~~

~~11/2014~~

~~Self-Insured Employer or Carrier Mail to:~~

~~NCIC - Claims Administration~~

~~4335 Mail Service Center~~

~~Raleigh, North Carolina 27699-4335~~

~~Main Telephone: (919) 807-2500~~

~~Helpline: (800) 688-8349~~

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

(a) ~~(Effective 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 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to 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 follows:

North Carolina Industrial Commission
Employer's Admission of Employee's Right to Permanent Partial Disability
(G.S. §97-31)

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

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

_____
Employee's Name
_____
Address
_____
City State Zip
_____
Home Telephone Work Telephone
Social Security Number: _____ 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 Number

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

1. All the 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 _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____.

4. The employee □ was □ was not paid for the 7 day waiting period.

If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.

6. The employee □ has □ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.

7. Claimant was released □ with permanent restrictions □ without permanent restrictions. <u>If claimant was released with permanent restrictions and has returned to work for the employer of injury, attach a job description if known to exist.</u>

8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. □ yes □ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.

The undersigned hereby certify that the material medical and vocational ~~reports~~ records related to the ~~injury~~ injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury, have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

Name Of Employer	Signature	Title	Date

Name Of Carrier/Administrator	Signature	Direct Phone Number	Email Address	Title	Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 3 of this form.

Signature of Employee	Address	Email Address	Date

Signature of Employee's Attorney	Address	Email Address	Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

Claims Examiner	Date

Attorney's fee approved

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 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.

Form 26A

~~7/2015~~ ~~[6/2020]~~ 12/2020

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

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at http://www.ic.nc.gov/forms/form26a.pdf. The form may be reproduced only in the format available at http://www.ic.nc.gov/forms/form26a.pdf and may not be altered or amended in any way.

History Note: Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;

Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23L .0103 is amended with changes as published in 34:20 NCR 1862-67 as follows:

11 NCAC 23L .0103 FORM 26A – EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY

~~*(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 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to 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 follows:*~~

~~*North Carolina Industrial Commission*~~
~~*Employer's Admission of Employee's Right to Permanent Partial Disability*~~
~~*(G.S. §97-31)*~~

~~*IC File #* _____~~
~~*Emp. Code #* _____~~
~~*Carrier Code #* _____~~
~~*Carrier File #* _____~~
~~*Employer FEIN* _____~~

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

_____
~~*Employee's Name*~~
_____
~~*Address*~~
_____
~~*City State Zip*~~
_____
~~*Home Telephone Work Telephone*~~
~~*Social Security Number:* _____ *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 Number*~~

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

~~*1. All the 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* _____.~~

3. The injury by accident or occupational disease resulted in the following injuries: _____.

4. The employee ☐ was ☐ was not paid for the 7 day waiting period.
If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? ☐ yes ☐ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.

6. The employee ☐ has ☐ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.

7. Claimant was released ☐ with permanent restrictions ☐ without permanent restrictions.

8. Permanent partial disability compensation will be paid to the injured worker as follows:
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. ☐ yes ☐ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check ☐ is ☐ is not included.

12. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.

Check one 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 employee and employer have agreed that the employer will pay the entire fee.

The undersigned hereby certify that the material medical and vocational reports related to the injury have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

_____

Name Of Employer Signature Title Date

_____

Name Of Carrier/Administrator Signature Direct Phone Number Title Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on pages 2 and 3 of this form.

_____

Signature of Employee Address Date

_____

Signature of Employee's Attorney Address_____Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

~~Attorney's fee approved~~

~~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 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.~~

~~Form 26A~~
~~11/2014~~

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

(a) ~~*(Effective 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 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to 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 follows:

North Carolina Industrial Commission
Employer's Admission of Employee's Right to Permanent Partial Disability
(G.S. §97-31)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
~~Employer FEIN _____~~

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

_____
Employee's Name

_____
Address

_____
City State Zip

_____
Home Telephone Work Telephone
Last 4 digits of Social Security Number: _____ 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 Number

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

1. All the 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 _____.
3. The injury by accident or occupational disease resulted in the following injuries: _____.
4. The employee ☐ was ☐ was not paid for the 7 day waiting period.

If not, was salary continued? ☐ yes ☐ no. Was employee paid for the date of injury? ☐ yes ☐ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.
6. The employee ☐ has ☐ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.
7. Claimant was released ☐ with permanent restrictions ☐ without permanent restrictions. *If claimant was released with permanent restrictions and has returned to work for the employer of injury, attach a job description if known to exist.*
8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. ☐ yes ☐ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check ☐ is ☐ is not included.

The undersigned hereby certify that the material medical and vocational ~~*reports*~~ *records* related to the ~~*injury*~~ *injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury,* have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

_____

Name Of Employer Signature Title Date

_____

Name Of Carrier/Administrator Signature Direct Phone Number *Email Address* Title Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 3 of this form.

_____

Signature of Employee Address *Email Address* Date

_____

Signature of Employee's Attorney Address *Email Address* Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

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 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 may be made on a Form 18M Employee's 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.

Form 26A
~~*7/2015* 6/2020~~[~~8/2020~~]2/2021

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"): ~~Carrier Mail to:~~
~~NCIC - Claims Administration~~
~~4335 Mail Service Center~~
~~Raleigh, North Carolina 27699-4335~~
~~Main Telephone: (919) 807-2500~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~
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

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at ~~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.ic.nc.gov/forms/form26a.pdf~~ https://www.ic.nc.gov/forms/form26a.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;
Amended Eff. December 1, 2020;
Amended Eff. February 1, 2021.

11 NCAC 23L .0105 is amended with changes as published in 34:20 NCR 1867-68 as follows:

11 NCAC 23L .0105 FORM T-42 – APPLICATION FOR APPOINTMENT OF GUARDIAN AD LITEM

(a) Persons seeking to appear on behalf of an infant or incompetent shall apply on a Form T-42, Application for Appointment of Guardian Ad Litem, in accordance with Rule 11 NCAC 23B .0203. The Form T-42, Application for Appointment of Guardian Ad Litem, shall read as follows:

North Carolina Industrial Commission
IC File # TA- _____
Application for Appointment of Guardian Ad Litem
The use of this Form is required under Rule 11 NCAC 23B .0203

_____ Plaintiff(s) v. _____Defendant(s)

To the North Carolina Industrial Commission:

The undersigned _____ respectfully shows unto the North Carolina Industrial Commission that _____ is an __ infant or __ incompetent without general or testamentary guardian in this State, and that by reason thereof can bring an action only by a guardian ad litem; that the infant or incompetent has a cause of action against the defendants on account of the following matter and things:
_____
The undersigned is a reputable person closely connected with the infant or incompetent having the relationship with the infant or incompetent as follows: _____

Wherefore, the undersigned prays the Commission that a fit and proper person be appointed Guardian Ad Litem for the infant or incompetent for the purpose of bringing on his or her behalf an action as above set out.
Signature of Applicant _____ Date_____

(Please complete page 2 of form)

Order Appointing Guardian Ad Litem

It appearing to the North Carolina Industrial Commission from the above application that _____ is an __ infant or __ incompetent having no general or testamentary guardian within this State and that said infant or incompetent appears to have a good cause of action against the defendant(s); and it further appearing to the Commission after due inquiry that _____ is a fit and proper person to be appointed guardian ad litem for the infant or incompetent for the purpose of bringing this action on his or her behalf;
It is therefore ordered that _____ be and is hereby appointed guardian ad litem of _____ to bring action on his or her behalf.

This _____ day of _____.

~~Commissioner or Deputy Commissioner~~ Commissioner, Deputy Commissioner, or Executive Secretary
_____

Please type or print:

Full name and address of minor or incompetent:
_____
Birth date of minor: _____
Full name and address of proposed guardian ad litem:
_____

Important Information for Parties
Parties should take notice of the provisions set forth in Rule 11 NCAC 23B .0203.

11 NCAC 23B .0203 Infants and Incompetents

(a) Persons seeking to appear on behalf of an infant or incompetent, in accordance with G.S. 1A-1, Rule 17, shall apply on a Form T-42 Application for Appointment of Guardian ad Litem. The Commission shall appoint a fit and proper person as guardian ad litem, if the Commission determines it to be in the best interest of the minor or incompetent. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person to be appointed.

(b) The Commission may assess a fee to be paid to an attorney who serves as a guardian ad litem for actual services rendered upon receipt of an affidavit of actual time spent in representation of the minor or incompetent as part of the costs.

ATTORNEYS: File via Electronic Document Filing Portal ("EDFP")
https://www.ic.nc.gov/docfiling.html
UNREPRESENTED PLAINTIFFS: File via EDFP, https://www.ic.nc.gov/docfiling.html OR
Mail to: Industrial Commission Clerk's Office, 1236 Mail Service Center, Raleigh NC 27699-1236 OR
File via hand delivery: Business days from 8 a.m. – 5 p.m., Dobbs Building, 6th floor, 430 N. Salisbury Street, Raleigh NC ~~[27603.]~~ 27603 OR Fax to (919) 715-0282 OR Email to dockets@ic.nc.gov.

~~SEND TO:~~
~~dockets@ic.nc.gov~~
~~Office of the Clerk~~
~~1236 Mail Service Center~~
~~Raleigh, NC 27699-1236~~
~~Main telephone: (919) 807-2500~~
~~Helpline (800) 688-8349~~
~~Website: http://www.ic.nc.gov~~

FORM T-42

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/formt42.pdf.~~ https://www.ic.nc.gov/forms/formt-42.pdf. The form shall be reproduced only in the format available at ~~http://www.ic.nc.ogv/forms/formt42.pdf~~ https://www.ic.nc.gov/forms/formt-42.pdf and shall not be altered or amended in any way.

History Note: *Authority G.S. 143-291; 143-295; 143-300;*
Eff. March 1, 2019;
Amended Eff. February 1, 2021.