North Carolina Industrial Commission

IC File #_____

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

Emp. Code #_____

Carrier Code #_____

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

Carrier File #_____

THIS FORM IS ONLY TO BE USED IN SETTLED CASES

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

1. Date of accident or disability from occupational disease _____.
2. Salary ☐ was / ☐ was not continued. Total Dollar Amount
3. Number of weeks temporary total _____ from _____ , through _____ $_____
   _____ from _____ , through _____ $_____
4. Number of weeks temporary partial _____ from _____ , through _____ $_____
   _____ from _____ , through _____ $_____
5. Number of weeks permanent partial _____ from _____ , through _____ $_____
6. Disfigurement amount paid $_____
7. Loss of organ or body part benefits paid $_____
8. TOTAL OF LINES 3 THROUGH 7 $_____
9. Compromise Settlement Agreement amount $_____
10. Total Medical Paid $_____

_____
NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR

_____
SIGNATURE TITLE DATE

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

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

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

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