

**NOTICE TO EMPLOYEE OF PAYMENT OF COMPENSATION
WITHOUT PREJUDICE (G.S. § 97-18(d)) OR PAYMENT OF
MEDICAL BENEFITS ONLY WITHOUT PREJUDICE
(G.S. § 97-2(19) & § 97-25)**

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

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

Employee's Name		Employer's Name		() - Telephone Number	
Address		Employer's Address		City	State Zip
City	State	Zip	Insurance Carrier	Policy Number	
() - 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	

TO EMPLOYEE (TO DEPENDENT(S) OR NEXT OF KIN IN CASES OF DEATH):

This is to inform you with regard to your claim for

☐ injury on ___ / ___ / ___ (date) (Specify body part(s) involved):

☐ occupational disease as of ___ / ___ / ___ (date) (Specify condition(s) and body part(s) involved):

☐ death on ___ / ___ / ___ (date)

TO EMPLOYER/CARRIER: FILL OUT ONLY THE APPLICABLE SECTION 1 OR 2 BELOW

NOTE: THE FOLLOWING ARE FOR INFORMATIONAL PURPOSES ONLY AND DO NOT CONSTITUTE AN AGREEMENT

SECTION 1: INDEMNITY BENEFITS

☐ Payments of workers' compensation benefits, both indemnity (money) and medical, will be made without prejudice to later deny your claim or Defendants' liability. Compensation may be continued during the investigation of your claim. The investigation may take up to 90 days, with a possible 30 day extension. During this period, Defendants may admit liability; contest your claim or Defendants' liability; or by Defendants' lack of action, waive the right to contest your claim.

The date on which Defendants first had written or actual notice of this claim was ___ / ___ / ___ (date)

Disability began on ___ / ___ / ___ (date) and the first payment of compensation is being mailed on ___ / ___ / ___ (date)

Subject to verification, employee's average weekly wage was \$_____, which results in a weekly compensation rate of \$_____.

SECTION 2: MEDICAL BENEFITS ONLY (PAID WITHOUT PREJUDICE, NOT SUBJECT TO 90-DAY REQUIREMENT IN SECTION 1 ABOVE)

☐ Payment of medical compensation is expressly being made without prejudice to Defendants to later deny the compensability of your claim. In the event you miss more than 7 days of work, you must notify your employer or carrier because you may be entitled to additional benefits. Completion of this section (Section 2) does not constitute an agreement to pay indemnity (money) benefits to you under G.S. § 97-18(d).

The date on which Defendants first had written or actual notice of this claim was ___ / ___ / ___ (date).

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR	TITLE	DATE
--	-------	------

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
[HTTP://WWW.IC.NC.GOV/DOCFILING.HTML](http://www.ic.nc.gov/docfiling.html)