North Carolina Industrial Commission

IC File # _____

AGREEMENT FOR COMPENSATION FOR DISABILITY

Emp. Code # _____

Carrier Code # _____

(G.S. § 97-82)

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

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

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

Name Of Employer	Signature	Title
Name Of Carrier / Administrator	Signature	Title

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

Signature of Employee	Address
Signature of Employee's Attorney	Address

☐ CHECK BOX IF NO ATTORNEY RETAINED.

☐ CHECK BOX IF EMPLOYEE IS IN MANAGED CARE.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

_____
CLAIMS EXAMINER **DATE**

_____
ATTORNEY'S FEE APPROVED

FORM 21

SELF INSURED EMPLOYER OR CARRIER,
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL (EDFP)
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

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 file an application for additional medical compensation pursuant to G.S. 97-95.1 within two years, or your right to these benefits may be lost. 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 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. 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.