SUBCHAPTER 23L – INDUSTRIAL COMMISSION FORMS

SECTION .0100 – WORKERS' COMPENSATION FORMS

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/

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North Carolina Industrial Commission
Agreement for Compensation for Disability
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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: _____.

_____

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.

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Form 21
7/2015

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/

(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. The form may be reproduced only in the format available at http://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.