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

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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 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 Page 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

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Form 26A
7/2015

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.