ASSOCIATED
CLAIMS
ADMINISTRATORS

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Worker's Compensation claims on behalf of National Liability & Fire Insurance Company and in partnership with North American Risk Services (NARS).

ACA and NARS professionals are experienced in Worker's Compensation Law. Please feel free to call our office with any questions you may have regarding your Worker's Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with to accomplish these goals.

You, the employer, are a vital part of making this happen. Listed below are some things you can do:

1. Report all work-related injuries as soon as you are aware of them.
2. You may report all work-related injuries by email at **claims@acaworkcomp.com** , fax to **1-800-988-4722,** or call **1-800-388-6268** for assistance reporting a claim.

After reporting your claim, you can contact NARS at **1-800-315-6090** for further assistance with your claim including:

1. Refer all medical authorization requests to NARS.
2. Communicate with your employee and NARS throughout the claim.
3. Have some light duty work available for restricted duty.
4. Advise NARS when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed. Fillable forms can also be downloaded at https://aiamga.com/workers-compensation/states-covered/.

We look forward to a long and pleasant working relationship with you and your employees.

Please call anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Worker's Compensation claims procedures.

Best regards,

Associated Claims Administrators

Frequently Asked Questions re: Claims

What is the "waiting period"?

Each state regulates the number of days an injured worker must be off work due to a work related injury before compensation (wage) payments may begin. This period is referred to as a "waiting period" and the number of days varies by state law. **The State of North Carolina defines the waiting period as 7 days. Compensation payments begin on the 8th day.**

Will an injured worker be paid for the days within the waiting period?

An injured worker may receive compensation payments for the number of days off comprising the waiting period, if he or she is out of work due to the injury longer than a specified period of time.

The reimbursement of waiting period for the State of North Carolina is defined as 21 days following the date of disability according to state law. If an injured worker's disability lasts longer than 21 days, he/she will be reimbursed for the 7 day waiting period.

How do we obtain a list of medical providers or the Employers' Posted Panel?

Rules and regulations regarding approved medical providers and/or Employers' Posted Panels for treatment of injured workers vary by state. It is important for every employer to understand how to identify and utilize medical providers and/or Employers' Posted Panels. For assistance obtaining a list of preferred providers and/or help setting up an Employers' Posted Panel, please contact the claims office at (800) 388-6268. **In North Carolina, the employer must authorize the selection of the treating physician.**

Do we have to provide light duty?

Providing light duty within the guidelines of a medically restricted employee of a compensable claim often shortens the length and reduces the total cost of the claim. While light duty may not be possible for some employers, it is recommended that all employers work to incorporate a light duty/return to work program.

How is the compensation rate calculated?

The compensation rate is 2/3 of the average weekly gross earnings of the injured worker. The number of weeks used for calculating varies by state and is subject to the state's minimum/maximum at the time of accident. The State of North Carolina uses gross wages where the "Average Weekly Wage" is calculated by taking the total wages paid for the last four quarters immediately preceding the quarter in which the injury occurred as reported on the Employment Security Commission's Employer Contribution Reports divided by fifty-two or by the actual number of weeks for which wages were paid, whichever is less.

How does the claimant obtain their medication?

The injured worker can obtain their medication from any pharmacy. They should provide the pharmacy with the contact information for ACA for further billing instructions and/or approval as provided below:

Associated Claims Administrators, Inc.	Toll Free:	(800) 388-6268
P.O. Box 230848	Fax (Toll Free):	(800) 988-4722
Montgomery AL 36123-0848	Email:	claims@acaworkcomp.com

If we have a deductible can we pay the claims up to the deductible amount?

No. A deductible applies per claim and is set up on a reimbursement basis. That means you, the employer, should file a First Report of Injury on all work related accidents. If our investigation leads to payment of the claim, we will cover costs first dollar and submit one or more invoices to you for reimbursement as payments are made up to the total/maximum per claim deductible amount noted on your policy.

Not all policies have a deductible. Your policy will include a deductible amount on the Workers' Compensation Policy Information Page if your policy has a deductible.

FORM 17 **Revised 12/2020**

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

- **Report the injury or occupational disease to the Employer immediately.**
- **Give written notice to the Employer within 30 days.**
- **File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.**
- **If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.**
- **Your employer's workers' compensation insurance carrier is_____ .**
- **The insurance policy number is_____ .**
- **Your employer's workers' compensation insurance policy is valid from_____ until_____ .**

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- **Provide all necessary medical services to the Employee.**
- **Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $4,000.00.**
- **Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.**

Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

NORTH CAROLINA
INDUSTRIAL COMMISSION

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, excepto oficiales ejecutivos expresamente excluídos.

SI USTED TIENE UNA LESIÓN RELACIONADA CON EL TRABAJO O UNA ENFERMEDAD OCUPACIONAL

El Empleado deberá:

- **Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.**
- **Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.**
- **Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional.**
- **Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia. Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.**
- **La compañía de seguros de compensación para trabajadores de su empleador es_____.**
- **El número de la póliza de seguro es_____.**
- **La póliza de seguro de compensación para trabajadores de su empleador es válida desde _____hasta_____.**

Para asistencia: Llame a la Comisión Industrial LÍNEA DE AYUDA—(800) 688-8349.

El Empleador deberá:

- **Proveer todos los servicios médicos necesarios al empleado.**
- **Reportar la lesión a la compañía de seguros/administrador y a la Comisión Industrial usando la Forma 19 Reporte de Accidente dentro de cinco (5) días, si su empleado falta más de un (1) día de trabajo o si los gastos de tratamientos médicos exceden los $4,000.00.**
- **Proveer a su empleado una copia de la Forma 19 y una copia en blanco de la Forma 18 Aviso de Accidente.**
- **Pagar puntualmente compensación al empleado de acuerdo con el Acta de Compensación Laboral.**

NORTH CAROLINA
INDUSTRIAL COMMISSION

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
Página Oficial en Español: www.ic.nc.gov

EMPLEADOR: ESTA FORMA DEBE ESTAR VISIBLEMENTE PUBLICADA SI USTED TIENE SEGURO DE COMPENSACIÓN LABORAL O SI USTED CALIFICA PARA ESTAR AUTOASEGURADO. (N.C. Gen. Stat. § 97-93).

North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT

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

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

Employee's Name	Employer's Name ( ) - Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier Policy Number
( ) - ( ) -	
Home Telephone ☐ M ☐ F Work Telephone	Carrier's Address City State Zip
- - / /	( ) - ( ) -
Social Security Number Sex Date of Birth	Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows:_____ (Time of Injury) on ___/___/___ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured:_____ Nature of employer's business: _____

Medical treatment received? ☐ Yes ☐ No Number of days out of work due to injury: _____

Weekly wage: $_____ Number of hours worked per day:_____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent	Printed Name of Signer	E-mail Address	( ) - Telephone Number

Address	City	State	Zip Code	/ / Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY: _____

FORM 18

ATTORNEYS: FILE WITH AN **IC FILE NUMBER** VIA **EDFP**
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
1235 MAIL SERVICE CENTER
RALEIGH, NC 27699-1235
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $4,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other two spaces "Emp. Code No." and "Carrier Code No." are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "3" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

North Carolina Industrial Commission

IC File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

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
- - Social Security Number	☐ M ☐ F Sex / / Date of Birth	( ) - Carrier's Telephone Number	( ) - Fax Number

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / /
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Date employment began (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No / Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI: HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:**
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

North Carolina Industrial Commission

IC File # _____

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

Emp. Code # _____

Carrier Code # _____

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

Carrier File # _____

Employee's Name

Address

City State Zip

Home Telephone Work Telephone

☐ M ☐ F / /

Last 4 Digits of SSN Sex Date of Birth

Date of Injury: _____

( ) -

Employer's Name Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) - ( ) -

Carrier's Telephone Number Fax Number

Year: **20**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned	
Jan.																																	
Feb.																																	
Mar.																																	
Apr.																																	
May																																	
June																																	
July																																	
Aug.																																	
Sept.																																	
Oct.																																	
Nov.																																	
Dec.																																	
																															Total		

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: $ _____ . _____ .

FORM 22

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

The undersigned employer of _____,
(Name of Employee)

who alleges an injury on the _____ of _____, **20**_____
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

_____
Employer

By _____

_____
Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

North Carolina Industrial Commission

IC File #_____

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

Emp. Code #_____

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

Carrier Code #_____

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

Carrier's Telephone Number Fax Number

For travel beginning January 1, 2024, employees are entitled to reimbursement of $0.67, provided they travel 20 miles or more roundtrip. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. § 97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP

OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense incurred through 6/30/23 (actual, up to $78.90 per day for in-state or $93.20 per day out-of-state). Total motel expense incurred on or after 7/1/23 (actual, up to $89.10 per day for in-state or $105.20 per day out-of-state).		Total Miles:	
		Total meal expense incurred through 6/30/23 ($9.00 Breakfast, $11.80 Lunch, and $20.50 Dinner in-state or $23.30 out-of-state). Total Meal expense incurred on or after 7/1/23 ($10.10 Breakfast, $13.30 Lunch, and $23.10 Dinner in-state or $26.30 out-of-state). :		**X [mileage rate]***	
		Total parking & cab expense (actual charge):		Other expenses:	
		Total for other expenses:		Total all expenses:	

*Prior mileage rates are as follows: (a) $0.655 for 2023; (b) $0.625 for 7/1/22-12/31/22; (c) $0.585 for 1/1/22-6/30/22; (d) $0.56 for 2021; (e) $0.575 for 2020 .

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Employee:
Mail your bill in duplicate promptly to employer and/or insurance carrier

Carrier's approval

Employer or Carrier/Administrator:
Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

NOTICE TO INJURED EMPLOYEE:
THIS FORM SHOULD BE RETURNED TO THE CARRIER AT THE ADDRESS ABOVE FOR PAYMENT.

FOR ASSISTANCE, CALL:
N.C. INDUSTRIAL COMMISSION
MAIN TELEPHONE: ***(919) 807-2500***
HELPLINE: ***(800) 688-8349***

FORM 25T

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

SUPPLEMENTAL REPORT FOR FATAL ACCIDENTS

(FORM 19, EMPLOYER'S REPORT OF EMPLOYEE'S INJURY TO THE INDUSTRIAL COMMISSION, MUST ALSO BE SUBMITTED IN EVERY CASE)

Carrier Code # _____

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence. Code numbers assigned to each employer and carrier should be inserted before mailing.

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

Deceased 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
Last 4 Digits of SSN / Sex ☐ M ☐ F / Date of Birth	Carrier's Telephone Number / Fax Number

1. Date of accident: _____ 2. Date of death: _____, 20 ____

3. Dependents, or if employee left no dependents, next of kin: (Indicate which are non-resident aliens)

	Name	Date of Birth	Relationship	Present Address
a.				
b.				
c.				
d.				
e.				
f.				

4. Immediate cause of death: _____

5. Amount of burial expenses authorized $ _____

Signature of Employer or Carrier/Administrator / Title / Date

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

FORM 29

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