North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

NOTICE OF REINSTATEMENT OR MODIFICATION OF COMPENSATION (G.S. §97-32.1 OR §97-18(b))

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
Date of Injury:			

Compensation in the amount of $. _____ per week was reinstated or modified on _____ pursuant to ☐ N.C. Gen. Stat. § 97-32.1

or

☐ N.C. Gen. Stat. § 97-18(b).

Give reason for reinstatement:

The employee's average weekly wage, including overtime and all allowances, was $. _____, which results in a weekly compensation rate of $. _____.

☐ a. Temporary total compensation is being paid at the compensation rate above.

☐ b. Temporary partial compensation is being paid in the amount of $. _____.

☐ c. Other: _____.

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR	**TITLE**	**/ / DATE**

Employer: The original of this form must be sent to the Industrial Commission at the address below. A copy shall be provided to the employee and the employee's attorney of record, if any.

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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