

APPLICATION TO REINSTATE PAYMENT OF DISABILITY COMPENSATION (G.S. 97-18(k))

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

Employee's Name _____
Address _____
City _____ State _____ Zip _____
Home Telephone () _____
Work Telephone () _____
Sex M F
Date of Birth _____
Social Security Number _____

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 () _____

IMPORTANT NOTICE TO EMPLOYER: The employee in this claim has applied for reinstatement of compensation. The employer or carrier must respond to this Application by completing Section B of this Form and returning one copy to the Industrial Commission within 10 days of receipt of this Form from the Industrial Commission. If the employer or carrier does not respond to this Application, an Order may be issued reinstating compensation. If you timely object to reinstatement, the matter will be scheduled for informal telephonic hearing.

SECTION A. TO BE COMPLETED BY THE EMPLOYEE:

1. Date of injury by accident or occupational disease: _____
2. Nature and extent of injury or occupational disease: _____

3. (a) Has your claim been accepted or determined to be compensable by the Industrial Commission: Yes: No:
(b) If so, how: Form 21 Form 60 Form 63 Opinion and Award
Other _____
4. Number of weeks compensation already paid: _____ From: _____ / _____ / _____ To: _____ / _____ / _____
5. Date from which seeking compensation: _____
6. Application is made to reinstate compensation on the grounds that: _____

YOU MUST ATTACH DOCUMENTATION TO SUPPORT THIS APPLICATION FOR REINSTATEMENT OF COMPENSATION.

NUMBER OF PAGES ATTACHED: _____

GIVE A TELEPHONE NUMBER AT WHICH YOU CAN BE REACHED IF AN INFORMAL HEARING IS SCHEDULED, FROM MONDAY THROUGH FRIDAY BETWEEN 8:00 A.M. AND 5:00 P.M.: _____ THE INDUSTRIAL COMMISSION WILL NOTIFY YOU IF AN INFORMAL HEARING IS SCHEDULED.

IN ADDITION TO FILING THE ORIGINAL OF THIS APPLICATION AND SUPPORTING DOCUMENTS WITH THE INDUSTRIAL COMMISSION, I HEREBY CERTIFY THAT A COPY OF THIS APPLICATION, TOGETHER WITH ALL SUPPORTING DOCUMENTS, WAS SENT TO THE EMPLOYER OR CARRIER/ADMINISTRATOR AT: (ADDRESS/FAX No): _____

SIGNATURE OF EMPLOYEE OR ATTORNEY: _____ DATE: _____

SEND TO: **NCIC - EXECUTIVE SECRETARY**
4333 MAIL SERVICE CENTER
RALEIGH, NC 27699-4333
MAIN TELEPHONE: (919) 807-2501
FAX NUMBER: (919) 733-5389
HELPLINE: (800) 688-8349
WEBSITE: <http://www.ic.nc.gov/>

SECTION B. TO BE COMPLETED BY THE EMPLOYER OR CARRIER/ADMINISTRATOR

1. THE EMPLOYER/CARRIER MUST COMPLETE EITHER 1 (a) OR 1.(b)

(a) If reinstatement of compensation is not contested, complete the following

Compensation in the amount of \$ _____ per week was or will be reinstated from _____ / _____ / _____
commencing on: _____ / _____ / _____

If compensation is reinstated on a date other than the date requested by the employee in Section A 5., please explain: _____

(b) Compensation should not be reinstated because: _____

2. (a) Specify whether this claim has been accepted, denied or determined compensable by the Industrial Commission: _____

(b) How: Form 61 Form 21 Form 60 Form 63 Opinion and Award
Other _____

3. If compensation has been paid, provide the number of weeks: _____ From: _____ / _____ / _____ To: _____ / _____ / _____

IF REINSTATEMENT OF COMPENSATION IS CONTESTED, GIVE A TELEPHONE NUMBER AT WHICH YOU CAN BE REACHED WHEN THE INFORMAL HEARING IS SCHEDULED, FROM MONDAY THROUGH FRIDAY BETWEEN 8:00 A.M. AND 5:00 P.M. _____ AND A FACSIMILE NUMBER OR E-MAIL ADDRESS FOR SERVICE OF THE HEARING NOTICE AND ANY OTHER CORRESPONDENCE.

IN ADDITION TO FILING THE ORIGINAL OF THIS RESPONSE WITH THE INDUSTRIAL COMMISSION, I HEREBY CERTIFY THAT A COPY OF THIS RESPONSE, TOGETHER WITH SUPPORTING DOCUMENTS, WAS SENT TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY OF RECORD, IF ANY, AT (ADDRESS/FAX NO.): _____

ON _____

SIGNATURE OF EMPLOYER,
CARRIER/ADMINISTRATOR OR
ATTORNEY: _____ DATE: _____

SEND TO: **NCIC - EXECUTIVE SECRETARY**
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