

# 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  
Social Security Number \_\_\_\_\_ 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 ( ) \_\_\_\_\_ 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:**

- Date of injury by accident or occupational disease: \_\_\_\_\_
- Nature and extent of injury or occupational disease: \_\_\_\_\_  
\_\_\_\_\_
- (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 \_\_\_\_\_
- Number of weeks compensation already paid: \_\_\_\_\_ From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Date from which seeking compensation: \_\_\_\_\_
- 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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