

1 11 NCAC 23L .0101 is amended with changes as published in 34:20 NCR 1853-58 as follows:

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11 NCAC 23L .0101 FORM 21 – AGREEMENT FOR COMPENSATION FOR DISABILITY

~~(a)(Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21, Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation therefor pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 21, Agreement for Compensation for Disability, shall read as follows:~~

North Carolina Industrial Commission
Agreement for Compensation for Disability
(G.S. 97-82)

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 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 or by _____.~~
3. ~~_____ The injury by accident or occupational disease resulted in the following injuries: _____.~~
4. ~~_____ The employee was/ was not paid for the entire day when the injury occurred.~~

5. _____ The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was \$ _____, subject to verification unless otherwise agreed upon in Item 9 below.

6. _____ Disability resulting from the injury or occupational disease began on _____.

7. _____ The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of \$ _____ per week beginning _____, and continuing for _____ weeks.

8. _____ The employee has / has not returned to work for _____ on _____, at an average weekly wage of \$ _____.

9. _____ State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: _____.

10. _____ If applicable, the Second Injury Fund Assessment is \$ _____. Check is is not attached.

11. _____ The date of this agreement is _____. Date of first payment: _____ Amount: _____.

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.

Name Of Employer _____ Signature _____ Title _____

Name Of Carrier / Administrator _____ Signature _____ Title _____

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Pages 1 and 2 of this form.

Signature of Employee _____ Address _____

Signature of Employee's Attorney _____ Address _____

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

Claims Examiner _____ Date _____

Attorney's Fee Approved

Check Box If No Attorney Retained.

Check Box If Employee Is In Managed Care.

~~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~~

1 ~~If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably~~
2 ~~necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.~~

3
4 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL~~
5 ~~MEDICAL BENEFITS~~

6 ~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several~~
7 ~~factors. Your right to payment of future medical compensation will terminate two years after your employer or~~
8 ~~carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think~~
9 ~~you will need future medical compensation, you must apply to the Industrial Commission in writing within two years,~~
10 ~~or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's~~
11 ~~Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~

12
13 ~~IMPORTANT NOTICE TO EMPLOYER~~

14
15
16 ~~The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC~~
17 ~~23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or~~
18 ~~carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the~~
19 ~~agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical~~
20 ~~Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

21
22 ~~NEED ASSISTANCE?~~

23
24 ~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at~~
25 ~~(800) 688-8349.~~

26
27 ~~Form 21~~
28 ~~11/2014~~

29
30 ~~Self Insured Employer or Carrier, Mail to:~~
31 ~~NCIC Claims Section~~
32 ~~4335 Mail Service Center~~
33 ~~Raleigh, NC 27699 4335~~
34 ~~Telephone: (919) 807-2502~~
35 ~~Helpline: (800) 688-8349~~
36 ~~Website: <http://www.ic.nc.gov/>~~
37

38 ~~(a)(Effective July 1, 2015)~~ The parties to a workers' compensation claim shall use the following Form 21, Agreement
39 for Compensation for Disability, for agreements regarding disability and payment of compensation therefor pursuant
40 to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent
41 partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501,
42 where applicable. The Form 21, Agreement for Compensation for Disability, shall read as follows:

43
44 North Carolina Industrial Commission
45 Agreement for Compensation for Disability
46 (G.S. 97-82)

47
48 IC File # _____
49 Emp. Code # _____
50 Carrier Code # _____
51 Carrier File # _____
52 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

Last 4 digits of 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 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 or by _____.
3. The injury by accident or occupational disease resulted in the following injuries: _____.
4. The employee was/ was not paid for the entire day when the injury occurred.
5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was \$ _____, subject to verification unless otherwise agreed upon in Item 9 below.
6. Disability resulting from the injury or occupational disease began on _____.
7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of \$ _____ per week beginning _____, and continuing for _____ weeks.
8. The employee has / has not returned to work for _____ on _____, at an average weekly wage of \$ _____.
9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: _____.
10. If applicable, the Second Injury Fund Assessment is \$ _____. Check is is not attached.
11. The date of this agreement is _____. Date of first payment: _____ Amount: _____.

Name Of Employer

Signature

Title

Name Of Carrier / Administrator

Signature

Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form.

Signature of Employee

Address

Signature of Employee's Attorney

Address

1 North Carolina Industrial Commission
2 The Foregoing Agreement Is Hereby Approved:

3
4 _____
Claims Examiner Date

5
6 _____
Attorney's Fee Approved

- 7
8 Check Box If No Attorney Retained.
9 Check Box If Employee Is In Managed Care.

10
11 IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM
12 PAYMENTS

13
14 Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial
15 Commission in writing within two years from the date of receipt of your last compensation check or your rights to
16 these benefits may be lost.

17
18 IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL
19 MEDICAL BENEFITS

20
21 If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably
22 necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

23
24 IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL
25 MEDICAL BENEFITS

26 If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several
27 factors. Your right to payment of future medical compensation will terminate two years after your employer or
28 carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think
29 you will need future medical compensation, you must apply to the Industrial Commission in writing file an application
30 for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be
31 lost. To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical
32 Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>. An application for additional medical
33 compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by
34 written request. In the alternative, an employee may file an application for additional medical compensation by filing
35 a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission
36 forms are available at <https://www.ic.nc.gov/forms.html>.

37
38 IMPORTANT NOTICE TO EMPLOYER

39
40 The employee must be provided a copy **of the form** when the agreement is signed by the employee. Pursuant to Rule
41 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or
42 carrier/administrator must submit the agreement to the Industrial Commission. Commission, or show cause for not
43 submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and
44 Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a
45 penalty.

46
47 NEED ASSISTANCE?

48
49 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
50 (800) 688-8349.

51
52 Form 21
53 7/2015 **[8/2020]** 3/2021

54
55 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"); Carrier, Mail to:
56 NCIC - Claims Section

1 ~~4335 Mail Service Center~~
2 ~~Raleigh, NC 27699-4335~~
3 ~~Telephone: (919) 807-2502~~
4 ~~Helpline: (800) 688-8349~~
5 ~~Website: <http://www.ic.nc.gov/>~~
6 ~~<https://www.ic.nc.gov/docfiling.html>~~
7 Contact Information:
8 NCIC- Claims Administration
9 Telephone: (919) 807-2502
10 Helpline: (800) 688-8349
11 Website: <https://www.ic.nc.gov/>

12 (b) The copy of the form described in Paragraph (a) of this Rule can be accessed at
13 ~~<http://www.ic.nc.gov/forms/form21.pdf>~~ <https://www.ic.nc.gov/forms/form21.pdf>. The form may be reproduced only
14 in the format available at ~~<http://www.ic.nc.gov/forms/form21.pdf>~~ <https://www.ic.nc.gov/forms/form21.pdf> and may
15 not be altered or amended in any way.

16

17 *History Note: Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
18 *Eff. November 1, 2014;*
19 *Recodified from 04 NCAC 10L .0101 Eff. June 1, 2018;*
20 *Amended Eff. March 1, 2021.*

1 11 NCAC 23L .0102 is amended with changes as published in 34:20 NCR 1858-62 as follows:

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11 NCAC 23L .0102 FORM 26 – SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION

~~(a)(Effective until July 1, 2015) If the parties to a workers' compensation claim have previously entered into an approved agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement as to Payment of Compensation, for agreements regarding subsequent additional disability and payment of compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of Compensation, shall read as follows:~~

North Carolina Industrial Commission
Supplemental Agreement as to Payment
of Compensation (G.S. §97-82)

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. Date of injury: _____

1 2. _____ The employee returned to work / was rated on _____ (date), at a weekly wage of
 2 \$ _____.
 3 3. _____ The employee became totally disabled on _____.
 4 4. _____ Employee's average weekly wage was reduced / was increased on _____, from \$ _____
 5 per week to \$ _____ per week.
 6 5. _____ The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate
 7 of \$ _____ per week.
 8 Beginning _____, and continuing for _____ weeks. The type of disability compensation is
 9 _____.

10 6. _____ State any further matters agreed upon, including disfigurement or temporary partial disability:
 11 _____.

12 7. _____ IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement
 13 is \$300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of
 14 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
 15 award is more than \$3,000.00, the employer shall deduct \$150.00 from your award, unless you and your employer
 16 agree otherwise.

17 Check one of the boxes below if the award is more than \$3,000.00:
 18 The employer will deduct \$150.00 from the amount to be paid pursuant to this agreement.
 19 The employee and employer have agreed that the employer will pay the entire fee.

20
 21 8. _____ The date of this agreement is _____.
 22 _____

23 Name Of Employer _____ Signature _____ Title _____

24
 25 Name Of Carrier/Administrator _____ Signature _____ Title _____
 26
 27

28 By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on
 29 Pages 1 and 2 of this form.

30
 31 Signature of Employee _____ Address _____

32
 33 Signature of Employee's Attorney _____ Address _____

34
 35 Check box if no attorney retained.

36
 37 North Carolina Industrial Commission
 38 The Foregoing Agreement Is Hereby Approved:

39
 40 Claims Examiner _____ Date _____
 41 _____

42 Attorney's fee approved
 43

44 ~~IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM~~
 45 ~~PAYMENTS~~

46 ~~Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial~~
 47 ~~Commission in writing within two years from the date of receipt of your last compensation check or your rights to~~
 48 ~~these benefits may be lost.~~

49
 50 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL~~
 51 ~~MEDICAL BENEFITS~~

52 ~~If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably~~
 53 ~~necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.~~

54
 55 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL~~
 56 ~~MEDICAL BENEFITS~~

1 ~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several~~
2 ~~factors. Your right to payment of future medical compensation will terminate two years after your employer or~~
3 ~~carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think~~
4 ~~you will need future medical compensation, you must apply to the Industrial Commission in writing within two years,~~
5 ~~or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's~~
6 ~~Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~

7
8 **IMPORTANT NOTICE TO EMPLOYER**
9

10
11 This form shall be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an
12 award in cases in which subsequent conditions require a modification of a former agreement or award. The employee
13 must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A
14 .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator
15 must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The
16 employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid,
17 within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.
18

19 **NEED ASSISTANCE?**
20

21 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
22 (800) 688-8349.
23

24 Form 26
25 11/2014
26

27 Self Insured Employer or Carrier Mail to:
28 NCIC - Claims Administration
29 4335 Mail Service Center
30 Raleigh, North Carolina 27699-4335
31 Main Telephone: (919) 807-2500
32 Helpline: (800) 688-8349
33 Website: <http://www.ic.nc.gov/>
34
35

36 (a) ~~(Effective July 1, 2015)~~ If the parties to a workers' compensation claim have previously entered into an approved
37 agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission of
38 Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement as
39 to Payment of Compensation, for agreements regarding subsequent additional disability and payment of compensation
40 pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for
41 permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC
42 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of Compensation, shall read as
43 follows:
44

45 North Carolina Industrial Commission
46 Supplemental Agreement as to Payment
47 of Compensation (G.S. §97-82)
48

49 IC File # _____
50 Emp. Code # _____
51 Carrier Code # _____
52 Carrier File # _____
53 Employer FEIN _____
54

55 The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act
56

1 _____
2 Employee's Name
3 _____
4 Address
5 _____
6 City State Zip
7 _____
8 Home Telephone Work Telephone
9 Last 4 digits of Social Security Number: _____ Sex: M F Date of Birth: _____
10

11 _____
12 Employer's Name Telephone Number
13 _____
14 Employer's Address City State Zip
15 _____
16 Insurance Carrier
17 _____
18 Carrier's Address City State Zip
19 _____
20 Carrier's Telephone Number Carrier's Fax Number
21

22 We, The Undersigned, Do Hereby Agree and Stipulate As Follows:
23 1. Date of injury: _____.
24 2. The employee returned to work / was rated on _____ (date), at a weekly wage of \$ _____.
25 3. The employee became totally disabled on _____.
26 4. Employee's average weekly wage was reduced / was increased on _____, from \$ _____
27 per week to \$ _____ per week.
28 5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of
29 \$ _____ per week.
30 Beginning _____, and continuing for _____ weeks. The type of disability compensation is
31 _____.
32 6. State any further matters agreed upon, including disfigurement or temporary partial disability:
33 _____.
34
35 7. The date of this agreement is _____.
36

37 Name Of Employer Signature Title
38 _____
39 Name Of Carrier/Administrator Signature Title
40 _____
41

42 By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on
43 Page 2 of this form.

44 _____
45 Signature of Employee Address
46 _____
47 Signature of Employee's Attorney Address
48 _____

49 Check box if no attorney retained.
50
51 North Carolina Industrial Commission
52 The Foregoing Agreement Is Hereby Approved:
53

54 Claims Examiner Date
55 _____
56 Attorney's fee approved

1
2 IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM
3 PAYMENTS

4 Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial
5 Commission in writing within two years from the date of receipt of your last compensation check or your rights to
6 these benefits may be lost.

7
8 IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL
9 MEDICAL BENEFITS

10 If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably
11 necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

12
13 IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL
14 MEDICAL BENEFITS

15 If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several
16 factors. Your right to payment of future medical compensation will terminate two years after your employer or
17 carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think
18 you will need future medical compensation, you must ~~apply to the Industrial Commission in writing~~ file an application
19 for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be
20 lost. ~~To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical~~
21 ~~Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~ An application for additional medical
22 compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by
23 written request. In the alternative, an employee may file an application for additional medical compensation by filing
24 a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission
25 forms are available at <https://www.ic.nc.gov/forms.html>.

26
27 IMPORTANT NOTICE TO EMPLOYER

28
29
30 This form shall be used only to supplement Form 21, *Agreement for Compensation for Disability* (G.S. 97-82), or an
31 award in cases in which subsequent conditions require a modification of a former agreement or award. The employee
32 must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A
33 .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator
34 must submit the agreement to the Industrial ~~Commission. Commission, or show cause for not submitting the~~
35 ~~agreement.~~ The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical*
36 *Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

37
38 NEED ASSISTANCE?

39
40 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
41 (800) 688-8349.

42
43 Form 26
44 7/2015 **8/2020** 3/2021

45
46 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"); ~~Carrier Mail to:~~

47 ~~NCIC - Claims Administration~~

48 ~~4335 Mail Service Center~~

49 ~~Raleigh, North Carolina 27699-4335~~

50 ~~Main Telephone: (919) 807-2500~~

51 ~~Helpline: (800) 688-8349~~

52 ~~Website: <http://www.ic.nc.gov/>~~

53 ~~<https://www.ic.nc.gov/docfiling.html>~~

54 Contact Information:

55 NCIC- Claims Administration

56 Telephone: (919) 807-2502

1 Helpline: (800) 688-8349
2 Website: <https://www.ic.nc.gov>
3

4 (b) The copy of the form described in Paragraph (a) of this Rule can be accessed at
5 ~~<http://www.ic.nc.gov/forms/form26.pdf>~~. ~~<https://www.ic.nc.gov/forms/form26.pdf>~~. The form may be reproduced only
6 in the format available at ~~<http://www.ic.nc.gov/forms/form26.pdf>~~ ~~<https://www.ic.nc.gov/forms/form26.pdf>~~ and may
7 not be altered or amended in any way.

8
9 *History Note: Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
10 *Eff. November 1, 2014;*
11 *Recodified from 04 NCAC 10L .0102 Eff. June 1, 2018;*
12 *Amended Eff. March 1, 2021.*

1 11 NCAC 23L .0103 is amended with changes as published in 34:20 NCR 1862-67 as follows:

2
3 **11 NCAC 23L .0103 FORM 26A – EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO**
4 **PERMANENT PARTIAL DISABILITY**

5 ~~(a) (Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 26A,~~
6 ~~Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's~~
7 ~~entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31.~~
8 ~~Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to~~
9 ~~G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where~~
10 ~~applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall read as~~
11 ~~follows:~~

12 *North Carolina Industrial Commission*
13 *Employer's Admission of Employee's Right to Permanent Partial Disability*
14 *(G.S. §97-31)*

15
16
17 *IC File #* _____
18 *Emp. Code #* _____
19 *Carrier Code #* _____
20 *Carrier File #* _____
21 *Employer FEIN* _____

22
23 *The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act*

24
25 _____
26 *Employee's Name*

27 _____
28 *Address*

29 _____
30 *City State Zip*

31 _____
32 *Home Telephone Work Telephone*

33 *Social Security Number: Sex: M F Date of Birth:* _____

34
35 _____
36 *Employer's Name Telephone Number*

37 _____
38 *Employer's Address City State Zip*

39 _____
40 *Insurance Carrier*

41 _____
42 *Carrier's Address City State Zip*

43 _____
44 *Carrier's Telephone Number Carrier's Fax Number*

45
46 *WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:*

47 *1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and*
48 *_____ is the Carrier/Administrator for the Employer.*

49 *2. The employee sustained an injury by accident or the employee contracted an occupational disease arising*
50 *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 _____

1
2 ~~Attorney's fee approved~~

3
4 ~~IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS~~
5 ~~Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial~~
6 ~~Commission in writing within two years from the date of receipt of your last compensation check or your rights to~~
7 ~~these benefits may be lost.~~

8
9 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL~~
10 ~~BENEFITS~~

11 ~~If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably~~
12 ~~necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.~~

13
14 ~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL~~
15 ~~MEDICAL BENEFITS~~

16 ~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several~~
17 ~~factors. Your right to payment of future medical compensation will terminate two years after your employer or~~
18 ~~carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think~~
19 ~~you will need future medical compensation, you must apply to the Industrial Commission in writing within two years,~~
20 ~~or your right to these benefits may be lost. To apply you may also use Industrial Commission 18M, Employee's~~
21 ~~Application for Additional Medical Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>.~~

22
23 ~~IMPORTANT NOTICE TO EMPLOYER~~

24 ~~The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC~~
25 ~~23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or~~
26 ~~carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the~~
27 ~~agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical~~
28 ~~Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

29
30 ~~NEED ASSISTANCE?~~

31 ~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at~~
32 ~~(800) 688-8349.~~

33
34 ~~Form 26A~~

35 ~~11/2014~~

36
37 ~~Self Insured Employer or Carrier Mail to:~~

38 ~~NCIC - Claims Administration~~

39 ~~4335 Mail Service Center~~

40 ~~Raleigh, North Carolina 27699-4335~~

41 ~~Main Telephone: (919) 807-2500~~

42 ~~Helpline: (800) 688-8349~~

43 ~~Website: <http://www.ic.nc.gov/>~~

44
45 ~~(a) (Effective July 1, 2015)~~ The parties to a workers' compensation claim shall use the following Form 26A,
46 ~~Employer's Admission of Employee's Right to Permanent Partial Disability~~, for agreements regarding the employee's
47 entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31.
48 Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to
49 G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501,
50 where applicable. The Form 26A, ~~Employer's Admission of Employee's Right to Permanent Partial Disability~~, shall
51 read as follows:

1 North Carolina Industrial Commission
2 Employer's Admission of Employee's Right to Permanent Partial Disability
3 (G.S. §97-31)
4
5 IC File # _____
6 Emp. Code # _____
7 Carrier Code # _____
8 Carrier File # _____
9 Employer FEIN _____

10
11 The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act
12

13
14 _____
15 Employee's Name
16 _____
17 Address
18 _____
19 City State Zip
20 _____
21 Home Telephone Work Telephone
22 Last 4 digits of Social Security Number: _____ Sex: M F Date of Birth: _____
23

24 _____
25 Employer's Name Telephone Number
26 _____
27 Employer's Address City State Zip
28 _____
29 Insurance Carrier
30 _____
31 Carrier's Address City State Zip
32 _____
33 Carrier's Telephone Number Carrier's Fax Number

34 WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:
35 1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and
36 _____ is the Carrier/Administrator for the Employer.
37 2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out
38 of and in the course of employment on _____.
39 3. The injury by accident or occupational disease resulted in the following injuries:
40 _____
41 4. The employee was was not paid for the 7 day waiting period.
42 If not, was salary continued? yes no. Was employee paid for the date of injury? yes no
43 5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances,
44 was \$ _____. This results in a weekly compensation rate of \$ _____.
45 6. The employee has has not returned full time to work for _____
46 on _____, at an average weekly wage of \$ _____.
47 7. Claimant was released with permanent restrictions without permanent restrictions. If claimant was
48 released with permanent restrictions and has returned to work for the employer of injury, attach a job description if
49 known to exist.
50 8. Permanent partial disability compensation will be paid to the injured worker as follows:
51 _____ weeks of compensation at rate of \$ _____ per week for _____ % rating to _____ (body part)
52 _____ weeks of compensation at rate of \$ _____ per week for _____ % rating to _____ (body part)
53 _____ weeks of compensation at rate of \$ _____ per week for _____ % rating to _____ (body part)
54 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.

The undersigned hereby certify that the material medical and vocational ~~reports~~ records related to the ~~injury~~ injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of 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 Email Address 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 Email Address Date

Signature of Employee's Attorney Address Email 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 file an application for additional medical compensation pursuant to G.S. 97-25.1 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~~

1 ~~Compensation (G.S. 97-25.1), available at <http://www.ic.nc.gov/forms.html>. An application for additional medical~~
2 ~~compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by~~
3 ~~written request. In the alternative, an employee may file an application for additional medical compensation by filing~~
4 ~~a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission~~
5 ~~forms are available at <https://www.ic.nc.gov/forms.html>.~~
6

7 **IMPORTANT NOTICE TO EMPLOYER**

8 The employee must be provided a copy **of the form** when the agreement is signed by the employee. Pursuant to Rule
9 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or
10 carrier/administrator must submit the agreement to the Industrial Commission. ~~Commission, or show cause for not~~
11 ~~submitting the agreement.~~ The employer or carrier/administrator shall file a Form 28B, Report of Compensation and
12 Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a
13 penalty.
14

15 **NEED ASSISTANCE?**

16 If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at
17 (800) 688-8349.
18

19 **Form 26A**

20 ~~7/2015 6/2020~~ **8/2020** ~~3/2021~~

21
22 Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"); Carrier Mail to:

23 ~~NCIC - Claims Administration~~

24 ~~4335 Mail Service Center~~

25 ~~Raleigh, North Carolina 27699-4335~~

26 ~~Main Telephone: (919) 807-2500~~

27 ~~Helpline: (800) 688-8349~~

28 ~~Website: <http://www.ic.nc.gov/>~~

29 ~~<https://www.ic.nc.gov/docfiling.html>~~

30 Contact Information:

31 NCIC- Claims Administration

32 Telephone: (919) 807-2502

33 Helpline: (800) 688-8349

34 Website: <https://www.ic.nc.gov>
35

36 (b) A copy of the form described in Paragraph (a) of this Rule can be accessed at
37 ~~<http://www.ic.nc.gov/forms/form26a.pdf>~~ ~~<https://www.ic.nc.gov/forms/form26a.pdf>~~. The form may be reproduced
38 only in the format available at ~~<http://www.ic.nc.gov/forms/form26a.pdf>~~ ~~<https://www.ic.nc.gov/forms/form26a.pdf>~~ and
39 may not be altered or amended in any way.
40

41 *History Note: Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*

42 *Eff. November 1, 2014;*

43 *Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;*

44 *Amended Eff. December 1, 2020;*

45 *Amended Eff. March 1, 2021.*