

**CLAIM BY EMPLOYEE, REPRESENTATIVE, OR DEPENDENT
FOR BENEFITS FOR LUNG DISEASE
INCLUDING ASBESTOSIS, SILICOSIS, BYSSINOSIS (G.S. 97-53)**

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

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 _____			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____			Carrier's Telephone Number _____		
						Fax Number _____			

exposure to: cotton dust , silica , asbestos , or other substance and, if known, state substance: _____
 Date of diagnosis _____ By- Dr _____ Attach diagnosing medical records

Employer-Defendants
 Attach additional pages if necessary

Employer Name: _____	Telephone: _____	Dates of Employment _____
Address: _____	City _____	State _____
	Zip _____	Location of Job(s) _____
Employer Name: _____	Telephone: _____	Dates of Employment _____
Address: _____	City _____	State _____
	Zip _____	Location of Job(s) _____
Employer Name: _____	Telephone: _____	Dates of Employment _____
Address: _____	City _____	State _____
	Zip _____	Location of Job(s) _____
Employer Name: _____	Telephone: _____	Dates of Employment _____
Address: _____	City _____	State _____
	Zip _____	Location of Job(s) _____

IT IS REQUIRED THAT BOTH PAGES OF THIS FORM BE COMPLETED IN ORDER TO PROCESS THIS CLAIM

FORM 18B
 2/01
 PAGE 1 OF 1

For IC use ONLY
Nature _____
Body _____
Cause _____
SIC _____
Coder _____

FORM 18B

MAIL TO:

**NCIC - CLAIMS SECTION
 4335 MAIL SERVICE CENTER
 RALEIGH, NORTH CAROLINA 27699-4335
 MAIN TELEPHONE: (919) 807-2500
 OMBUDSMAN: (800) 688-8349**

Employment History, Beginning With Most Recent Employment (Attach additional pages if necessary):

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			
Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			
Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			

List the names and addresses of all family physicians, treating physicians and hospitals that have provided medical services or treatment to you over a 20 year period prior to the filing of this claim.

Year	Name	Address (City)	Purpose for which treated (if known)

I hereby authorize the above named medical sources to disclose medical records (including images such as x-rays, CT scans, MRIs, sonograms, etc.) regarding my treatment, hospitalization, and/or outpatient care for any condition during the period(s) Identified above to all parties (Including insurance companies) or State agencies that may review my application for compensation. I also hereby authorize that a photocopy of this authorization be accepted with the same authority as this original. The information disclosed will be used in connection with my claim for benefits under the Workers' Compensation Act.

I understand this authorization will automatically expire when my application for benefits is finally decided.

Signature of (Check One) <input type="checkbox"/> Employer, <input type="checkbox"/> Attorney, <input type="checkbox"/> Representative, or <input type="checkbox"/> Dependent	Telephone Number
--	------------------

Address	City	State	Zip	Date Completed
---------	------	-------	-----	----------------

Employee should return original of this form to the Industrial Commission, furnish his/her employer with one signed copy, and retain a copy.

MAIL TO:

FORM 18B ADDITIONAL EMPLOYMENT

Employment History

Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			
Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			
Employer	From / To:	Employer's Type of Business	Employee's Job Title
If you were exposed to the listed substance(s) while working for this employer, describe in detail the exposures:			