North Carolina Industrial Commission

IC File #________

Emp. Code #________

Carrier Code #________

Carrier File #________

Employer FEIN ________

SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION (G.S. 97-82)

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 ________

Home Telephone ( ) ________ Work Telephone ( ) ________ | Carrier's Address ________ City ________ State ________ Zip ________

Social Security Number ________ Sex ‘ M ‘ F Date of Birth / / | Carrier's Telephone Number ( ) ________ Fax Number ( ) ________

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

1. The employee ‘ returned to work / ‘ was rated on ________ (date), at a weekly wage of $ ________.
2. The employee became totally disabled on ________.
3. Employee's average weekly wage ‘ was reduced / ‘ was increased on ________ , from $ ________ per week to $ ________ per week.
4. The employee was rated as having ____% permanent partial impairment of the following part of the body: ________
5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $ ________per week beginning ________, and continuing for ________weeks. The type of disability compensation is________
6. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: ________
7. If applicable, the Second Injury Fund Assessment is $ ________. Check ‘ is ‘ is not attached.
8. The date of this agreement is ________.

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 the reverse side of this form.

SIGNATURE OF EMPLOYEE ________ ADDRESS ________

SIGNATURE OF EMPLOYEE'S ATTORNEY ________ ADDRESS ________

☐ Check box if no attorney retained.

NORTH CAROLINA INDUSTRIAL COMMISSION
THE FOREGOING AGREEMENT IS HEREBY APPROVED:

CLAIMS EXAMINER ________ DATE ________

ATTORNEY'S FEE APPROVED ________

MAIL TO: ***NCIC - CLAIMS SECTION***
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349
www.comp.state.nc.us

FORM 26

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 5 JULY 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before 5 July 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 5 JULY 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after 5 July 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 you 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 within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M.

IMPORTANT NOTICE TO EMPLOYER

This form is to be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Failure to file Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after last payment pursuant to this agreement may subject the employer or carrier/administrator to a penalty. Pursuant to Rule 501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show good cause for not submitting the agreement.

NEED ASSISTANCE?

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

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