AGREEMENT FOR PAYMENT OF UNPAID COMPENSATION IN UNRELATED DEATH CASES (G. S. 97- 3.7)

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	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 ☐ M ☐ F / Date of Birth	Carrier's Telephone Number / 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 North Carolina Workers' Compensation Act.
2 Deceased employee contracted an occupational disease or sustained an injury by accident arising out of and in the course of employment on ____________________(date of accident or occupational disease).
3. The accident or occupational disease resulted in the following injury and disability : ____________________

   ____
   Description of injury and permanent disability
4. The employee earned an average weekly wage of $ __________, which resulted in payment of compensation at the rate of $ ________ per week for temporary total disability for _____weeks covering the period from __________ to __________ and for permanent partial disability for __________weeks, and is entitled to the unpaid balance of__________weeks of permanent partial disability compensation for ____________________
   Rating of body part pursuant to G.S. 97-31
5. Employee died on ____________________ , from causes unrelated to the occupational disease or injury by accident referenced in No. 2 above.
6. The following is/are the ☐ whole dependent(s), ☐ partial dependent(s), ☐ next of kin, ☐ or personal representative of the estate of deceased employee: ____________________
7. The parties agree to pay and receive the balance of the compensation at the rate of $ __________ per week for a period of ________weeks beginning ____________________

____
Signature of dependent, next of kin or personal representative

____
Signature of Employer Title

____
Signature of dependent, next of kin or personal representative

____
Signature of Carrier/Administrator Title

____
Signature of claimant's attorney

____
Attorney's address

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