

**NOTICE OF REINSTATEMENT OR MODIFICATION OF  
COMPENSATION (G. S. 97-32.1 OR 97-18(b))**

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

Compensation in the amount of \$ \_\_\_\_\_ per week was reinstated or modified on \_\_\_\_\_ pursuant to  N.C. Gen. Stat. § 97-32.1 or  N.C. Gen. Stat. § 97-18(b).

Give reason for reinstatement:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The employee's average weekly wage, including overtime and all allowances, was \$ \_\_\_\_\_, which results in a weekly compensation rate of \$ \_\_\_\_\_.

- a. Temporary total compensation is being paid at the compensation rate above.
- b. Temporary partial compensation is being paid in the amount of \$ \_\_\_\_\_.
- c. Other: \_\_\_\_\_

SIGNATURE OF EMPLOYER/ADMINISTRATOR \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_

Employer: The original of this form must be sent to the Industrial Commission at the address below. A copy shall be provided to the employee and the employee's attorney of record, if any.

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