North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

Employer FEIN _____

REPORT OF EMPLOYER OR CARRIER/ADMINISTRATOR OF COMPENSATION AND MEDICAL COMPENSATION PAID PURSUANT TO A COMPROMISE SETTLEMENT AGREEMENT

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

THIS FORM IS ONLY TO BE USED IN SETTLED CASES

Employee's Name _____

Address _____

City _____ State _____ Zip _____

( ) Home Telephone _____ ( ) Work Telephone _____

Social Security Number _____ ☐ M ☐ F Sex _____ / / 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 _____ ( ) Fax Number _____

1. Date of accident or disability from occupational disease _____.
2. Salary ☐ was / ☐ was not continued.

						Total Dollar Amount
3.	Number of weeks temporary total	_____	from _____	, through	_____	$_____
		_____	from _____	, through	_____	$_____
4.	Number of weeks temporary partial	_____	from _____	, through	_____	$_____
		_____	from _____	, through	_____	$_____
5.	Number of weeks permanent partial	_____	from _____	, through	_____	$_____

6. Disfigurement amount paid $_____
7. Loss of organ or body part benefits paid $_____
8. TOTAL OF LINES 3 THROUGH 7 $_____
9. Compromise Settlement Agreement amount $_____
10. Total Medical Paid $_____

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR _____

SIGNATURE _____ TITLE _____ DATE _____

This form must be filed with the Industrial Commission at the address below.

FOR INDUSTRIAL COMMISSION USE ONLY

Days _____

Compensation Paid $_____

Medical $_____

IC Code: _____

FORM 28C
11/2003
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MAIL TO:

NCIC - STATISTICS SECTION
4334 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4334
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

FORM 28C