AmTrust North America
An AmTrust Financial Company

North Carolina
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

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AmTrust INSURANCE

Workers' Compensation Claim Reporting Information

24/7 Toll Free Claim Reporting for All States

(888)239-3909

WorkersCompClaimReport@AmTrustgroup.com

www.amtrustfinancial.com

Information Required for All Claims Reported

1. Name of the insured and policy number
2. Name, social security number and contact information of injured worker
3. Date, time and place of accident
4. Description of accident or incident
5. Name, phone, and/or email of person making the report
6. Any information on the injured workers lost time

Early claim reporting is essential to a better claim outcome. Don't delay reporting if you do not have all the details.

How do I help my injured worker find a doctor?

- We offer an online physician search for all states, www.talispoint.com/amtrust/external
- For California, www-lv.talispoint.com/amtrust/campn
- For CO, GA, PA & TN, please refer to the panel provided by AmTrust via mail or email

How does my injured employee receive prescription medications related to the accident/injury?

- Refer to the claims kit for your state at www.talispoint.com/amtrust/external for a First Fill card for your injured employee to use at the pharmacy to cover the cost of approved medication.

Timely Reporting

When a work-related injury occurs, it is important to act immediately. Timely reporting of a new claim helps to provide a smooth and successful claim process for both you and your injured worker.

We're Here To Help

After your claim has been filed, we may be in touch to obtain additional information. Our goal is to offer a smooth and hassle-free experience – from your first contact to the claims conclusion. Feel free to also call us with any questions. We're here to help.

Relax And Stay Positive

You have the assurance of our knowledge, expertise, and understanding of the claim process. We're with you all the way.

877.528.7878 I www.amtrustfinancial.com

AmTrust INSURANCE

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
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Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

800 Superior Avenue E • 21st Floor • Cleveland, OH 44114
(p) 866.203.3037 • (f) 800.487.9654 • www.amtrustnorthamerica.com

North Carolina Industrial Commission

IC File #_____

NOTICE OF ACCIDENT TO EMPLOYER AND CLAIM OF EMPLOYEE, REPRESENTATIVE, OR DEPENDENT

Emp. Code #_____

Carrier Code #_____

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

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

Employee's Name	Employer's Name ( ) - Telephone Number
Address	Employer's Address City State Zip
City State Zip	Insurance Carrier: C/O AmTrust North America; Policy Number
( ) - ( ) -	PO Box 89404 Cleveland, OH 44101
Home Telephone ☐ M ☐ F Work Telephone	Carrier's Address City State Zip
- - / /	(888) 239- 3909 ( ) -
Social Security Number Sex Date of Birth	Carrier's Telephone Number Carrier's Fax Number

EMPLOYEE – This form must be filed with the Industrial Commission within two years of the date of injury or occupational disease or your claim may be barred. Notice shall be given to the employer immediately after the accident or as soon as practicable and within 30 days. (This form should also be used for occupational disease claims; however, for asbestosis, silicosis and byssinosis, Form 18B is to be used.)

Notice is hereby given, as required by law, that the above-named employee sustained an injury or contracted an occupational disease, described as follows: _____ (Time of Injury) on ____/__/____ (Date (required)) at _____ (City and County). Describe the injury or occupational disease, including the specific body part involved (e.g., right hand, left hand) _____

Describe how the injury or occupational disease occurred: _____

Occupation when injured: _____ Nature of employer's business: _____

Medical treatment received? ☐ Yes ☐ No Number of days out of work due to injury: _____

Weekly wage: $_____ Number of hours worked per day: _____ Days worked per week: _____

NOTE: If employee is unable to sign this form, another may sign for him. This form should be typed or printed by hand in black ink, if possible. Employee should retain one signed copy of this notice, mail one signed copy to the Industrial Commission at the address below, and provide one signed copy to employer.

Signature of (Check One) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ Dependent	Printed Name of Signer	E-mail Address	( ) - Telephone Number
Address	City	State	Zip Code / / Date Completed

EMPLOYER: This notice is being sent to you in compliance with requirements of the North Carolina Workers' Compensation Act, in order that the medical services prescribed by the Act may be obtained; and, if disability extends beyond 7 days duration, or if death ensues, compensation may be paid according to law.

FOR IC USE ONLY

RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES: E-MAIL TO FORMS@IC.NC.GOV
OR MAIL TO: NCIC - CLAIMS SECTION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
MAIN PHONE: (919) 807-2500 HELPLINE: (800) 688-8349

FORM 18

GENERAL INFORMATION ON THE FORM 18

1. What does a Form 18 do?

A Form 18 establishes a legal claim of injury on your behalf if filed within two years of the date of injury or occupational disease, and gives the required written notice to the employer if a copy is submitted to the employer within 30 days of the injury. The employer is required by law to file a Form 19 if the employee misses more than one day of work due to the injury or if the medical bills exceed $4,000.00. However, the employer's filing of a Form 19 does not satisfy the employee's obligation to file a claim. In order to ensure the employee's rights are protected, the employee must file a Form 18 even though the employer may be paying compensation or the Industrial Commission may have opened a file for the injury.

2. To whom should the Form 18 be sent?

The original Form 18 should be submitted to the Industrial Commission. The injured worker should keep one copy for his or her records and one copy should be submitted to the employer at the time of the injury.

3. What numbers do I write in the upper right corner?

You do not need to fill in the spaces on the upper right corner of the Form 18. If you know that your employer has already filed a report of injury, (Form 19) and you know what your I.C. (Industrial Commission), File Number is, you may write the number in the "I.C. File No." space. If you do not already have an I.C. File Number, the Industrial Commission will assign one upon receipt of the Form 18. The other two spaces "Emp. Code No." and "Carrier Code No." are for internal use only.

4. What if I do not know who my employer's insurance carrier is?

If you do not know who the employer's insurance carrier is you may either ask your employer for the information, call the Industrial Commission's Claims Administration Section at (800) 688-8349 then press "3" after the prompt, or simply leave the line blank.

5. When listing the number of days out of work, do I count partial days?

Yes, you include partial as well as whole calendar days not worked. However, the days do not need to be consecutive.

6. What happens after I file the Form 18?

The Industrial Commission will mail an acknowledgement letter to you after your Form 18 is processed. Processing time varies according to current workload. The Industrial Commission will mail a copy of the acknowledgement letter to the employer or its workers' compensation insurance carrier asking them to contact you and inform you if compensation will be paid to you voluntarily.

North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

AVISO DE ACCIDENTE Y RECLAMO DEL EMPLEADO, REPRESENTANTE Ó DEPENDIENTE *(G.S. 97-22 HASTA 24)*

(Notice of Accident to Employer and Claim of Employee, Representative, or Dependent [*G.S. 97-22 through 24*])

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

El uso de esta forma se requiere bajo las provisiones de la Ley de Compensación Laboral para empleados.

Declaración de Divulgación de Número de Seguro Social

La Ley de Registros Públicos de Norte Carolina (N.C. Est. Gen. § 132-1.10) permite que la Comisión Industrial de Norte Carolina pida el número de seguro social de un individuo cuando el hacer tal cosa sea imperativo a la realización de sus deberes y responsabilidades. El propósito tras el pedir el número de seguro social de usted en este formulario es para que la Comisión industrial pueda verificar el empleador correcto con el North Carolina Department of Commerce ("Departamento de Comercio de Norte Carolina"), Division of Employment Security ("División de Seguridad de Empleo") y poder identificar cobertura de seguro de compensación laboral. La divulgación de un número de seguro social por un individuo a la Comisión Industrial es voluntaria. Números de seguro social son confidenciales y exentos de revelación pública por la Comisión Industrial. La Comisión Industrial no podrá compartir el número de seguro social de usted a menos que sea así permitido según N.C. Est. Gen. § 132.10.

Nombre del empleado

Domicilio

Ciudad Estado Código Postal

( ) Teléfono en el hogar

( ) Teléfono en el trabajo

Número de Seguro Social ☐ M ☐ F Sexo / / Fecha de Nacimiento

Nombre del empleador ( ) Número de telefóno

Domicilio del patrón

Ciudad Estado Código Postal

Portador de Aseguranza

EMPLEADO – Esta Forma debe ser enviada a la Comisión Industrial dentro los dos años siguiendo la fecha del la lesión o enfermedad laboral o su reclamo será excluído. Deberá avisarle a su empleador immediatamente después del accidente o tan pronto sea posible dentro de 30 días. (Esta Forma debe ser usada también para reportar una enfermedad de oficio; sin embargo, para asbestosis, silicosis y byssinosis, La Forma 18B debe ser usada.)

Aviso se da por este medio, segun los requisitos de la ley, que el empleado sufrió una lesión ó contrajo una enfermedad de oficio descrito como sigue: _____ (Hora de la lesión) el _____ (Fecha (Requerido)) en _____ (Ciudad y Condado). Describa la lesión ó enfermedad incluyendo la parte del cuerpo específicamente envuelta (e.g.mano derecha, mano izquierda)

Describe cómo ocurrió la lesión ó la enfermedad de oficio: _____

Ocupación el día del accidente: _____ Naturaleza del negocio del empleador: _____

Número de días fuera del trabajo debido a la lesión:

Recibió tratamiento medico: ☐ Si ☐ No

Compensación semanal: _____ Número de horas que trabaja cada dia: _____ Dias que trabaja por semana: _____

EMPLEADOR: Este aviso se le envia conforme con los requisitos del Acta de Compensación Laboral de Carolina del Norte; para poder obtener los servicios médicos prescritos por el Acta; y, si está incapacitado más de 7 días, o si resulta en la muerte, la indemnización puede ser pagada según la ley.

Firma (Check One) ϒ Empleado, ϒ Abogado, ϒ Representante, ó ϒ Dependiente

( ) Número telefónico

Domicilio Ciudad Estado Código postal Fecha Completado

AVISO – Si el lesionado no puede firmar esta forma, entonces otra persona puede firmar por él. Esta forma debe ser llenada a máquina si es posible, o con su letra en tinta negra. El trabajador debe quedarse con una copia, envie el original a la Comisión Industrial a la dirección que esta escrita en el mismo formulario, y envie una copia a su empleador.

For IC use ONLY
Nature
Body
Cause
SIC
Coder

FORMA 18

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES: E-MAIL TO: **FORMS@IC.NC.GOV**
OR MAIL TO: **NCIC - CLAIMS SECTION**
1235 MAIL SERVICECENTER
RALEIGH, NC 27699-1235
MAIN TELEPHONE**: (919) 807-2500** HELPLINE: **(800) 688-8349**

Informacion General Del Formulario 18

1. Qué es la Forma 18?

La forma 18 establece un reclamo legal al reportar heridas que hayan resultado de un accidente de trabajo. Debe ser sometida dentro de 2 años de la fecha de accidente o diagnóstico de la enfermedad de oficio. También satisface el requisito de notificarle al patrón por escrito, que ha ocurrido un accidente en el trabajo. Esta notificación debe ser entregada al patrón dentro de 30 días del acontecimiento o puede notificarlo verbalmente. El patrón tiene la obligación por ley de someter una Forma 19 si usted pierde un día de trabajo por resultado del accidente o si los gastos médicos exceden $4,000. Sin embargo, la Forma 19 no satisface la obligación del trabajador a someter una reclamación. El trabajador debe someter la Forma 18 para protejer sus derechos aunque esté recibiendo benficios o aunque la Comisión Industrial tenga un expediente abierto de su accidente.

2. A quién se le debe enviar la Forma 18?

La forma original debe ser enviada a la Comisión Industrial a la dirección que está en el mismo papel. El trabajador lesionado debe mantener una copia y otra copia debe ser entregada al patrón cuando ocurre la lesión.

3. Qué números debo escribir en la esquina superior derecha?

Usted no tiene que escribir nada en la esquina superior derecha en la Forma 18. Si Ud. sabe que su empleador ya sometió el reporte de la lesión (Forma 19) y usted sabe cuál es el número de archivo de IC (de la Comisión Industrial) usted puede escribir ese número en el espacio que dice “IC File #”. Si usted no tiene todavía un número de IC, entonces la Comisión Industrial le asignará un número cuando la forma sea procesada. Los otros tres espacios “Emp. Code No.,” “Carrier Code No.,” y “Employer FEIN” son para uso interno solamente.

4. Qué pasa si yo no sé cuál es el portador de seguro que tiene mi patrón?

Si usted no sabe quién es el portador de seguro, le puede preguntar a su patrón o puede llamar a la Comisión Industrial para obtener información al 1-800-688-8349 (marque el numero 3) o puede dejar esa línea en blanco.

5. Cuando se lista el número de días fuera del trabajo, cuentan los días parciales?

Si, Ud. debe incluir tanto el tiempo parcial como los días calendarios completos que no haya trabajado. Sin embargo, los días no necesitan ser consecutivos.

6. Qué pasa después que yo envié la Forma 18?

La Comisión Industrial le enviará una carta de reconocimiento después que la Forma 18 sea procesada. El período de procesamiento puede variar de acuerdo al cargo de trabajo. La Comisión Industrial también le va a enviar una copia de reconocimiento al portador de seguro, pidiéndole a ellos que lo contacten y le informen si le van a pagar los beneficios voluntariamente.

North Carolina Industrial Commission

IC File #_____

CLAIM BY EMPLOYEE, REPRESENTATIVE, OR DEPENDENT FOR BENEFITS FOR LUNG DISEASE

Emp. Code #_____

Carrier Code #_____

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

Social Security Number Disclosure Statement

The North Carolina Public Records Act (N.C. Gen. Stat. § 132-1.10) permits the North Carolina Industrial Commission to request a social security number from an individual when doing so is imperative to the performance of its duties and responsibilities. The purpose of requesting your social security number on this form is for the Industrial Commission to verify the correct employer with the North Carolina Department of Commerce, Division of Employment Security and to identify workers' compensation insurance coverage. The disclosure of a social security number by an individual to the Industrial Commission is voluntary. Social security numbers are confidential and exempt from public disclosure by the Industrial Commission. The Industrial Commission may not share your social security number unless otherwise permitted to do so pursuant to N.C. Gen. Stat. § 132-1.10.

Employee's Name	☐ M ☐ F / / Social Security Number Sex Date of Birth
Address	If Employee is deceased, list Personal Representative
City State Zip	Spouse's Name
( ) ( ) Employee's Home Telephone Work Telephone	Name of Attorney if represented

PRINT OR TYPE ALL ANSWERS

Notice is hereby given, as required by law, that the above-named employee sustained an occupational disease caused by exposure to: cotton dust ; silica ; asbestos ; or other substance and, if known, state substance: _____.

Date of diagnosis _____ By: Dr. _____ Attach diagnosing medical records.

Date of death, if applicable_____

List of Employer-Defendants (Attach additional pages if necessary). NOTE: While you are not required to attach your SSA Earnings Report to this form, doing so will help confirm that you have listed the correct employers on this form.

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____

Address: _____ Location of Job(s) _____

City State Zip _____

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____

Address: _____ Location of Job(s) _____

City State Zip _____

Employer Name: _____ Telephone: (___) _____ Dates of Employment _____

Address: _____ Location of Job(s) _____

City State Zip _____

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

FORM 18B

ATTORNEYS: FILE VIA EDFP
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML
EMPLOYEES: E-MAIL TO FORMS@IC.NC.GOV
OR MAIL TO: NCIC - CLAIMS SECTION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
MAIN PHONE (919) 807-2500 HELPLINE: (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) ☐ Employee, ☐ Attorney, ☐ Representative, or ☐ 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.

ATTORNEYS: FILE VIA EDFP HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

EMPLOYEES: E-MAIL TO FORMS@IC.NC.GOV

OR MAIL TO: NCIC - CLAIMS SECTION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
MAIN PHONE (919) 807-2500 HELPLINE: (800) 688-8349

North Carolina Industrial Commission

IC File #_____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

Emp. FEIN_____

Carrier FEIN_____

Carrier File #_____

To the Employer:
A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. The filing of this report is required by law.
This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

To the Employee:
This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed **Form 18** and mail it to Claims Administration, N.C. Industrial Commission, 1235 Mail Service Center, Raleigh, NC 27699-1235 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

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
			C/O AmTrust North America		
City	State	Zip	Insurance Carrier	Policy Number	
( ) -	( ) -		PO Box 89404	Cleveland, OH	44101
Home Telephone	Work Telephone		Carrier's Address	City	State Zip
- -	☐ M ☐ F	/ /	(888)239-3909	( ) -	
Social Security Number	Sex	Date of Birth	Carrier's Telephone Number	Fax Number	

Employer	1.	Give nature of employer's business
Time And Place	2.	Location of plant where injury occurred County Department State if employer's premises
	3.	Date of injury / / 4. Day of week Hour of day : ☐ A.M. ☐ P.M.
	5.	Was employee paid for entire day 6. Date disability began / /
	7.	Date you or the supervisor first knew of injury / / 8. Name of supervisor
Person Injured	9.	Occupation when injured
	10.	(a) Date employment began (b) Wages per hour $
	11.	(a) No. hours worked per day (b) Wages per day $ (c) No. of days worked per week (d) Avg. weekly wages w/ overtime $ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. $ per
Cause And Nature Of Injury	12.	Describe fully how injury occurred and what employee was doing when injured: (Statement made without prejudice and without vouching for correctness of information)
	13.	List all injuries and specify body part involved (e.g. right hand or left hand):
	14.	Date & hour returned to work / / at : .M. 15. If so, at what wages $ per
	16.	At what occupation 17. Employee's salary continued in full?
	18.	Was employee treated by a physician
Fatal Cases	19.	Has injured employee died 20. If so, give date of death (Submit Form 29) / /

Employer name _____ Date Completed / /

Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log:	Date Hired: / /	Time Employee began work on date of incident: : ☐ A.M. ☐ P.M.	If off-site medical treatment provided, answer entire next line.	
Name of facility:		Address: Street/City/Zip/Telephone	ER visit? ☐ Yes ☐ No	Overnight stay? ☐ Yes ☐ No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

FOR IC USE ONLY
RESEARCHER:_____
CC:_____
EC:_____
DATA ENTRY:_____

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI**: **HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML**

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: FORMS@IC.NC.GOV OR MAIL TO: NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235
MAIN TELEPHONE: (919) 807-2500 HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para ceriorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED PUEDE HABLAR AL (800) 688-8349

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN *[I.C. FILE NUMBER]* (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.

FORM 19

SELF-INSURED EMPLOYER OR CARRIER, FILE AS **FROI** VIA **EDI:**
HTTP://WWW.IC.NC.GOV/EDIFORM19.HTML

UNINSURED EMPLOYERS OR LUNG DISEASE CLAIMS:
E-MAIL TO: **FORMS@IC.NC.GOV** OR MAIL TO: **NCIC - CLAIMS SECTION, 1235 MAIL SERVICE CENTER, RALEIGH, NC 27699-1235**
MAIN TELEPHONE: **(919) 807-2500** HELPLINE: **(800) 688-8349**
WEBSITE: **HTTP://WWW.IC.NC.GOV/**

North Carolina Industrial Commission

IC File #_____

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

Emp. Code #_____

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

Carrier Code #_____

Employee's Name

Address

City State Zip

( ) -
Home Telephone

( ) -
Work Telephone

Employer's Name ( ) -
Telephone Number

Employer's Address City State Zip

C/O AmTrust North America
Insurance Carrier

PO Box 89404 Cleveland OH 44101
Carrier's Address City State Zip

(888)239-3909 ( ) -
Carrier's Telephone Number Fax Number

For travel beginning January 1, 2024, employees are entitled to reimbursement of $0.67, provided they travel 20 miles or more roundtrip. Special consideration will be given to employees who are totally disabled. No reimbursement is allowed for trips to purchase medications or supplies unless medically necessary. These items must be purchased on visits to medical providers (G.S. § 97-25).

DATE	NAME OF MEDICAL PROVIDER	CITY	TOTAL MILES ROUNDTRIP
/ /			
/ /			
/ /			
/ /			
/ /			

OTHER EXPENSES	If overnight stay is necessary, the following items will be approved as submitted. (Receipts must be furnished for carrier's file.)	Total motel expense incurred through 6/30/23 (actual, up to $78.90 per day for in-state or $93.20 per day out-of-state). Total motel expense incurred on or after 7/1/23 (actual, up to $89.10 per day for in-state or $105.20 per day out-of-state).		Total Miles:	
		Total meal expense incurred through 6/30/23 ($9.00 Breakfast, $11.80 Lunch, and $20.50 Dinner in-state or $23.30 out-of-state). Total Meal expense incurred on or after 7/1/23 ($10.10 Breakfast, $13.30 Lunch, and $23.10 Dinner in-state or $26.30 out-of-state). :		**X [mileage rate]***	
		Total parking & cab expense (actual charge):		Other expenses:	
		Total for other expenses:		Total all expenses:	

*Prior mileage rates are as follows: (a) $0.655 for 2023; (b) $0.625 for 7/1/22-12/31/22; (c) $0.585 for 1/1/22-6/30/22; (d) $0.56 for 2021; (e) $0.575 for 2020 .

I hereby certify that I have incurred all expenses listed above as a result of my workers' compensation injury.

Employee signature

Employee:
Mail your bill in duplicate promptly to employer and/or insurance carrier

Carrier's approval

Employer or Carrier/Administrator:
Travel may be reimbursed directly to the employee. It is not necessary to submit bills to the Commission for approval. Pay and retain copy in carrier's file.

NOTICE TO INJURED EMPLOYEE:
THIS FORM SHOULD BE RETURNED TO THE CARRIER AT THE ADDRESS ABOVE FOR PAYMENT.

FOR ASSISTANCE, CALL:
N.C. INDUSTRIAL COMMISSION
MAIN TELEPHONE: ***(919) 807-2500***
HELPLINE: ***(800) 688-8349***

FORM 25T

North Carolina Industrial Commission

IC File # _____

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

Emp. Code # _____

Carrier Code # _____

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

Carrier File # _____

Employee's Name

Address

City State Zip

( ) - ( ) -
Home Telephone Work Telephone

XXX-XX- ☐ M ☐ F / /
Last 4 Digits of SSN Sex Date of Birth

Date of Injury: / /

( ) -
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

Year: **20**	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Amount Earned	
Jan.																																	
Feb.																																	
Mar.																																	
Apr.																																	
May																																	
June																																	
July																																	
Aug.																																	
Sept.																																	
Oct.																																	
Nov.																																	
Dec.																																	
																															Total		

Was this employee given free rent, lodging, or board or other allowances made in lieu of wages? _____

If so, state weekly value thereof: $ _____ .

FORM 22

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

The undersigned employer of _____,
(Name of Employee)

who alleges an injury on the _____ of _____, **20**__
(Day) (Month) (Year)

while in the employment of the undersigned, does hereby certify that the above is a true and correct statement of days worked and earnings of this employee during the 52 weeks immediately preceding the injury (or during the above weeks and parts thereof, if employed for less than 52 weeks) and while engaged in the occupation in which the employee was allegedly injured.

_____
Employer

By _____
Authorized Signature

/ /20__
Date Signed

To Employer: Making a false statement for the purpose of denying workers' compensation benefits may result in civil or criminal penalties.

INSTRUCTIONS

This form must be completed and filed with the Commission in all cases resulting in death unless maximum compensation rate is stipulated. It must also be filed in any other case if there is a disagreement about earnings or if the Commission requests it.

In preparing this form, place an X in the proper squares to indicate days paid in full. Days the employee is on paid vacation leave and/or paid sick leave should be marked with an X. Leave blank squares to indicate days not paid in full for any reason. Total earnings for each pay period should be placed in the proper column. If the employee's job or pay rate was changed during the reported period, this should be noted, with an indication as to the nature of the change.

The employer code number and the carrier code number, if any, must be inserted in the proper place at the upper right-hand corner of the form.

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

FORM 17 **Revised 12/2020**

N.C. WORKERS' COMPENSATION NOTICE TO INJURED WORKERS AND EMPLOYERS

All employees of this business, except specifically excluded executive officers, suffering work-related injuries may be entitled to Workers' Compensation benefits from the employer or its insurance carrier.

IF YOU HAVE A WORK-RELATED INJURY OR AN OCCUPATIONAL DISEASE

The Employee Should:

- **Report the injury or occupational disease to the Employer immediately.**
- **Give written notice to the Employer within 30 days.**
- **File a claim with the Industrial Commission on a Form 18 immediately, but no later than 2 years from injury date or occupational disease. Give a copy to the Employer.**
- **If medical treatment and wage loss compensation are not promptly provided, call the insurance carrier/administrator or request a hearing before the Industrial Commission using a Form 33 Request for Hearing. Commission forms are available at website www.ic.nc.gov or by calling the Help Line.**
- **Your employer's workers' compensation insurance carrier is_____ .**
- **The insurance policy number is_____ .**
- **Your employer's workers' compensation insurance policy is valid from_____ until_____ .**

For assistance: Call the Industrial Commission HELP LINE—(800) 688-8349.

The Employer Should:

- **Provide all necessary medical services to the Employee.**
- **Report the injury to the carrier/administrator and file a Form 19 Report of Injury within 5 days with the Industrial Commission, if the Employee misses more than 1 day from work or if cumulative medical costs exceed $4,000.00.**
- **Give a copy of your completed Form 19 to the Employee along with a copy of a blank Form 18 Notice of Accident.**

Ensure that compensation is promptly paid as required under the Workers' Compensation Act.

NORTH CAROLINA
INDUSTRIAL COMMISSION

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235

Website: www.ic.nc.gov

TO EMPLOYER: THIS FORM MUST BE PROMINENTLY POSTED IF YOU HAVE WORKERS' COMPENSATION INSURANCE OR QUALIFY AS SELF-INSURED. (N.C. Gen. Stat. §97-93).

AVISO DE COMPENSACIÓN LABORAL A EMPLEADORES Y EMPLEADOS LESIONADOS

Todo empleado de este negocio que sufre lesiones relacionadas al trabajo puede tener derecho a beneficios de compensación laboral por parte del empleador o el portador de seguro del empleador, excepto oficiales ejecutivos expresamente excluídos.

SI USTED TIENE UNA LESIÓN RELACIONADA CON EL TRABAJO O UNA ENFERMEDAD OCUPACIONAL

El Empleado deberá:

- **Reportar inmediatamente su lesión o enfermedad ocupacional a su empleador.**
- **Notificar por escrito al empleador dentro de treinta (30) días que ocurre la lesión o enfermedad ocupacional.**
- **Hacer inmediatamente un reclamo a la Comisión Industrial usando la Forma 18, no más tarde de (2) años de ocurrir o desarrollar su lesión o enfermedad ocupacional.**
- **Si el tratamiento médico o el pago de compensación no es prontamente suministrado, llame a la compañía de seguros/administrador o requiera una audiencia ante la Comisión Industrial usando la Forma 33 Petición que la Demanda sea Asignada a una Audiencia. Las formas de la Comisión están disponibles en la página web www.ic.nc.gov o llamando a la Línea de Ayuda.**
- **La compañía de seguros de compensación para trabajadores de su empleador es_____.**
- **El número de la póliza de seguro es_____.**
- **La póliza de seguro de compensación para trabajadores de su empleador es válida desde _____hasta_____.**

Para asistencia: Llame a la Comisión Industrial LÍNEA DE AYUDA—(800) 688-8349.

El Empleador deberá:

- **Proveer todos los servicios médicos necesarios al empleado.**
- **Reportar la lesión a la compañía de seguros/administrador y a la Comisión Industrial usando la Forma 19 Reporte de Accidente dentro de cinco (5) días, si su empleado falta más de un (1) día de trabajo o si los gastos de tratamientos médicos exceden los $4,000.00.**
- **Proveer a su empleado una copia de la Forma 19 y una copia en blanco de la Forma 18 Aviso de Accidente.**
- **Pagar puntualmente compensación al empleado de acuerdo con el Acta de Compensación Laboral.**

NORTH CAROLINA
INDUSTRIAL COMMISSION

NORTH CAROLINA INDUSTRIAL COMMISSION
1235 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1235
Página Oficial en Español: www.ic.nc.gov

EMPLEADOR: ESTA FORMA DEBE ESTAR VISIBLEMENTE PUBLICADA SI USTED TIENE SEGURO DE COMPENSACIÓN LABORAL O SI USTED CALIFICA PARA ESTAR AUTOASEGURADO. (N.C. Gen. Stat. § 97-93).

I.C. Form MSC2 (rev. 03/2022)

NORTH CAROLINA INDUSTRIAL COMMISSION

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

I.C. File No. _____
Carrier No. _____
_____County

NCIC-Mediation Section
mediation@ic.nc.gov
1236 Mail Service Center
Raleigh, NC 27699-1236

_____
Plaintiff

v.

_____
Defendant

_____
Carrier

PETITION FOR ORDER REFERRING CASE TO MEDIATED SETTLEMENT CONFERENCE

Appearances

_____ _____
Name of Plaintiff or Plaintiff's Attorney | Telephone and Fax numbers of Plaintiff or Plaintiff's Attorney

_____
Email Address of Plaintiff or Plaintiff's Attorney

_____ _____
Name of Defendant or Defendant's Attorney | Telephone and Fax numbers of Defendant or Defendant's Attorney

_____
Email Address of Defendant or Defendant's Attorney

Now comes the undersigned party, petitioning the Commission to order the above captioned case to a mediated settlement conference pursuant to the Rules for Mediated Settlement Conferences of the Industrial Commission, and in support of the Petition says:

This case should be ordered to a mediated settlement conference for the following reasons (attach additional pages if necessary, designated with the I.C. file number and titled "Attachment to Form MSC2"):

_____

_____

Notice to parties: Objections must be filed in writing with the Commission within 10 days of the service of this petition and may be ruled on by the Commission without further hearing.

The foregoing motion was served by Petitioner on all non-moving parties by way of (check one): ____ Email ____ U.S. Mail

as listed (list name and email or mailing address of each party served): _____

This the _____ day of _____, ____.

Petitioner: _____

IC Form MSC3 (rev. 05/2024)

THIS FORM IS TO BE USED UNDER THE RULES FOR MEDIATED SETTLEMENT CONFERENCES OF THE

NORTH CAROLINA INDUSTRIAL COMMISSION

I. C. File No. _____

_____

Plaintiff

v.

_____

Defendant

_____

Carrier

ORDER FOR MEDIATED SETTLEMENT CONFERENCE

APPEARANCES

_____ _____

Name of Plaintiff or Plaintiff's Attorney | Telephone and Fax numbers of Plaintiff or Plaintiff's Attorney

_____

Email Address of Plaintiff or Plaintiff's Attorney

_____ _____

Name of Defendant or Defendant's Attorney | Telephone and Fax numbers of Defendant or Defendant's Attorney

_____

Email Address of Defendant or Defendant's Attorney

IT IS HEREBY ORDERED that the parties in the above captioned case and their attorneys shall participate in a mediated settlement conference, pursuant to NC General Statutes 97-80(c) and 143-296 and the Rules for Mediated Settlement Conferences of the North Carolina Industrial Commission. The conference shall be completed within 120 days from the date of this Order.

IT IS FURTHER ORDERED that the parties shall have 21 days from the date of this Order to select a mediator by agreement or designate a list of mediators by agreement from which the Commission will select a mediator. Within 21 days from the date of this Order, the parties shall file a stipulation as to the mediator on IC Form MSC4, *Designation of Mediator*, or a notice of the parties' failure to agree on a mediator. *See* Rule 11 NCAC 23G .0102.

The parties and a mediator selected by agreement shall agree upon the mediator's rate of compensation. A mediator appointed by the Commission will be compensated at the rate of $150 per hour for time spent in the mediated settlement conference, to be billed in quarter hour segments, in addition to a $150 administrative fee, in accordance with Rule 11 NCAC 23G .0107.

All parties, their attorneys, and individuals with authority to settle the claim shall attend the mediated settlement conference, as set forth in Rule 11 NCAC 23G .0104(a).

At least 15 days prior to mediation, the parties shall exchange all medical and rehabilitation records available to the parties related to the injury in question and any recorded statements, expert opinions, reports, tapes, photographs, and other documents that are relevant or material to the issues in controversy.

If there is a pending request for hearing, this case will be set for hearing on the next available calendar, and the hearing date may be prior to the deadline for completing mediation. Any request to continue a hearing to a later date to allow additional time to mediate the case prior to hearing shall be filed with the Deputy Commissioner assigned to hear the case. If the case is settled prior to hearing, it will be removed from the hearing calendar following notice of the settlement to the Deputy Commissioner assigned to hear the case.

HEREBY ENTERED AND ORDERED, this ___ day of _____, _____.

NORTH CAROLINA INDUSTRIAL COMMISSION

By: _____
Dispute Resolution Coordinator

IC Form MSC4 (rev. 05/2024) **NORTH CAROLINA INDUSTRIAL COMMISSION**

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

I.C. File No. _____
Carrier No. _____
_____County

NCIC-Mediation Section
mediation@ic.nc.gov
1236 Mail Service Center
Raleigh, NC 27699-1236

_____
Plaintiff
v.
_____
Defendant
_____
Carrier

DESIGNATION OF MEDIATOR

Appearances

Plaintiff'sAttorney_____**Telephone**_____

Email Address_____**Fax**_____

Defendant's Attorney_____**Telephone**_____

Email Address_____**Fax**_____

Contact Information for IC Form MSC5 (Report of Mediator) Invoicing

Individual to whom invoice should be sent:

Name: _____
Company/Organization: _____
Email Address: _____

THIS FORM IS TO BE COMPLETED BY EITHER THE PLAINTIFF OR THE DEFENDANT WITHIN THE TIME SPECIFIED IN THE COMMISSION'S ORDERS AND THE ICMSC RULES.

Pursuant to the Order entered in the above captioned case, referring it to a mediated settlement conference, the parties have selected the DRC certified mediator named below, who has agreed to serve.

Mediator's name _____ Telephone _____

Email Address _____ Fax _____

The mediation conference is scheduled to convene on the following date: _____.

If the scheduled date is more than 120 days from the Order for Mediated Settlement Conference and the parties jointly request an extension of time to mediate, check here: _____

This the ___ day of _____, _____.

_____
Signature of Plaintiff / Defendant or Representative

IC Form MSC5 (rev. 03/2022) **NORTH CAROLINA INDUSTRIAL COMMISSION**

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

I.C. File No. _____
Carrier No. _____
_____County

NCIC-Mediation Section
mediation@ic.nc.gov
1236 Mail Service Center
Raleigh, NC 27699-1236

_____, Plaintiff

v.

REPORT OF MEDIATOR

_____, Defendant
_____, Carrier

Mediator_____telephone _____fax _____

Email Address_____

The undersigned mediator reports the following results of a mediated settlement conference in this case:

Conference ___ **was held** and **completed** on:_____.
____**was held** but **not completed** because_____.
___ **was not held because**: _____.
Anticipated Date of Completion:_____ Number of sessions held: _____

Names of parties, attorneys, insurance representatives or others who were absent: _____

_____

The parties reached:___ agreement on all issues. ___ an impasse. ___ agreement on the following issues:

_____

If this case was not settled in mediation, and there is a pending request for hearing, the parties estimate that the length of the hearing in this case will be _____.

Issues settled to be disposed of by: ___ clincher ___ other agmt. ___ voluntary dismissal ___ removal from hearing docket

The person who will submit the agreement/clincher /dismissal to the Commission is _____

_____, who will submit it by _____ (date).

Mediator's Fee

ADMINISTRATIVE FEE: $_____
($150.00 for appointed mediator)

MEDIATION FEE: $_____
Total time spent in Mediated Settlement Conference: _____.___ hours
($150.00 per hour for appointed mediator, billed in quarter hour segments.)

OTHER FEE (Postponement fee, etc...., if any) $_____

TOTAL FEE $_____
All fees to the mediator have been paid except as follows:
Party owing fee Amount owed Email address of party

_____

I have returned this report to the Commission within seven days of the conclusion of the mediated settlement conference.

This the ___ day of _____, _____. _____
Mediator

This report is to be returned to the Commission in all cases, whatever the mediation results.

IC Form MSC6 (rev. 03/2022)

NORTH CAROLINA INDUSTRIAL COMMISSION

E-mail to: mediation@ic.nc.gov
N.C. Industrial Commission
Mediation Section
1236 Mail Service Center
Raleigh, NC 27699-1236

MEDIATOR'S DECLARATION OF INTEREST AND QUALIFICATIONS

Mediator

_____

Email Address _____

Mailing Address _____

_____ _____
Telephone

_____ _____
Fax

Please complete Section 1 ***or*** *Section 2.*

Section 1

I am qualified pursuant to Rule 11 NCAC 23G.0108(b) and desire appointment in cases pending before the Commission. I certify my qualification by initialing each of the following, as applicable:

_____ I am a mediator certified by the North Carolina Dispute Resolution Commission to conduct Mediated Settlement Conferences in Superior Court cases.

_____ If an attorney, I am in good standing with the North Carolina State Bar.

_____ I agree to accept and perform mediations of disputes before the Industrial Commission with reasonable frequency when called upon, for the fees and at rates of payment specified by the Industrial Commission.

_____ I have completed the following North Carolina State Bar approved continuing legal education course(s) on workers' compensation law within the last two years:

Date Course title and CLE credit given Provider

_____

_____

_____

Section 2

Pursuant to Rule 11 NCAC 23G.0108(c), I, the above named mediator, request that the North Carolina Industrial Commission place my name on the list of mediators with similar qualifications which the Commission makes available to parties selecting mediators in cases pending before the Commission. My pertinent qualifications and experience are:

_____

_____

_____

I have successfully completed the following mediation training:

Date of training Course title and hours of training Provider

_____

_____

_____

If the training was not certified by the Dispute Resolution Commission or sponsored by a Center belonging to the Mediation Network of North Carolina, please attach a copy of the training agenda and a list of the trainers.

I will notify the Commission if and when any of the above declarations or qualifications listed above no longer obtain.

This the ___ day of _____ ,_____.

_____

Signature of Mediator

Please indicate how many hours (one-way) you are willing to drive to conduct mediation conferences in cases in which you are appointed as the mediator by the Commission

:_____

North Carolina Industrial Commission
1236 Mail Service Center
Raleigh, NC 27699-1236

To: New Mediator
From: Tammy R. Nance, Acting Dispute Resolution Coordinator

Due to the high settlement rates and positive responses to the use of mediation in workers' compensation cases, the Commission has begun sending all cases to mediation upon the filing of a Form 33 Request for Hearing. To assist the parties in selecting a mediator, we are developing a roster of mediators which includes a summary of their background and experience. Please fill out the questionnaire below, and return this form to the Industrial Commission. If you do not complete it, you will still be one of our listed mediators, but you will not be included in the more descriptive roster. If you have any questions, please contact me at tammy.nance@ic.nc.gov. Please also note that the revised mediator report forms that you will begin receiving ask for an estimate of the length of the hearing in those cases that are not settled in mediation.

If your address or contact numbers are incorrect, please mark the changes on this form.

How many hours one way are you willing to drive to conduct mediations assigned to you by the Commission? _____

When did you become an AOC/DRC certified mediator? _____

Approximately how many court cases have you mediated? _____

Approximately how many workers' compensation cases have you mediated? _____

Please state the approximate number of cases in which you have represented a party in a workers' compensation claim _____.

In what percentage of these workers' compensation cases have you represented:
Employees_____%
Employers or Insurance Carriers_____%

Please provide me with your hourly mediation fee, per case administration fee, and your policies and charges (if any) for cancellations, travel time and expenses in those cases where you are selected by agreement of the parties to be the mediator in IC cases.

Hourly Mediation Fee_____
Administration Fee_____
Cancellation Fee_____
Travel Fee_____
Describe below or on a separate sheet in no more than 50 words your past experience in handling workers'compensation cases (i.e. plaintiffs' attorney, defense attorney, mediator, insurance adjuster, Industrial Commission staff, etc.)

Thank you for your assistance.