

Dear Employer:

Associated Claims Administrators (ACA) will be administering your Workers' Compensation claims on behalf of National Liability & Fire Insurance Company.

ACA professionals are experienced in Workers' Compensation Law. Please feel free to call our office with any questions you may have regarding your Workers' Compensation concerns.

Early involvement in a claim is important. It is not only cost effective for you, but it also can help the injured employee get proper medical care and return to work as soon as possible. We look forward to working with you to accomplish these goals.

You, the employer, are a vital part of making this happen and listed below are some things you can do:

- **Review the attached list of Frequently Asked Questions.**
- Report all work related injuries to ACA as soon as you are aware of them. Our toll free fax number is 1-800-988-4722.
- You may report all work related injuries to ACA by email at claims@acaworkcomp.com.
- Refer all medical authorization requests to ACA.
- Communicate with your employee and ACA throughout the claim.
- Have some light duty work available for restricted duty.
- Advise ACA when the employee returns to work.

Please keep copies of the attached forms to have on hand if needed.

We look forward to a long and pleasant working relationship with you and your employees.

Please call ACA anytime between 8:00am and 5:00pm Central Time, Monday through Friday if you have any questions regarding Workers' Compensation claims procedures.

Thank you.

Sincerely,

Associated Claims Administrators

Frequently Asked Questions re: Claims

What is the “waiting period”?

Each state regulates the number of days an injured worker must be off work due to a work related injury before compensation (wage) payments may begin. This period is referred to as a “waiting period” and the number of days varies by state law. **The State of North Carolina defines the waiting period as 7 days. Compensation payments begin on the 8th day.**

Will an injured worker be paid for the days within the waiting period?

An injured worker may receive compensation payments for the number of days off comprising the waiting period, if he or she is out of work due to the injury longer than a specified period of time.

The reimbursement of waiting period for the State of North Carolina is defined as 21 days following the date of disability according to state law. If an injured worker’s disability lasts longer than 21 days, he/she will be reimbursed for the 7 day waiting period.

How do we obtain a list of medical providers or the Employers’ Posted Panel?

Rules and regulations regarding approved medical providers and/or Employers’ Posted Panels for treatment of injured workers vary by state. It is important for every employer to understand how to identify and utilize medical providers and/or Employers’ Posted Panels. For assistance obtaining a list of preferred providers and/or help setting up an Employers’ Posted Panel, please contact the claims office at (800) 388-6268. **In North Carolina, the employer must authorize the selection of the treating physician.**

Do we have to provide light duty?

Providing light duty within the guidelines of a medically restricted employee of a compensable claim often shortens the length and reduces the total cost of the claim. While light duty may not be possible for some employers, it is recommended that all employers work to incorporate a light duty/return to work program.

How is the compensation rate calculated?

The compensation rate is 2/3 of the average weekly gross earnings of the injured worker. The number of weeks used for calculating varies by state and is subject to the state’s minimum/maximum at the time of accident. The State of North Carolina uses gross wages where the “Average Weekly Wage” is calculated by taking the total wages paid for the last four quarters immediately preceding the quarter in which the injury occurred as reported on the Employment Security Commission’s Employer Contribution Reports divided by fifty-two or by the actual number of weeks for which wages were paid, whichever is less.

How does the claimant obtain their medication?

The injured worker can obtain their medication from any pharmacy. They should provide the pharmacy with the contact information for ACA for further billing instructions and/or approval as provided below:

Associated Claims Administrators, Inc.
P.O. Box 230848
Montgomery AL 36123-0848

Toll Free: (800) 388-6268
Fax (Toll Free): (800) 988-4722
Email: claims@acaworkcomp.com

If we have a deductible can we pay the claims up to the deductible amount?

No. A deductible applies per claim and is set up on a reimbursement basis. That means you, the employer, should file a First Report of Injury on all work related accidents. If our investigation leads to payment of the claim, we will cover costs first dollar and submit one or more invoices to you for reimbursement as payments are made up to the total/maximum per claim deductible amount noted on your policy.

Not all policies have a deductible. Your policy will include a deductible amount on the Workers’ Compensation Policy Information Page if your policy has a deductible.

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 \$2,000.00.
- 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.

**For assistance with Safety Education Training contact:
Director of Safety Education at (919) 807-2602 or safety@ic.nc.gov**



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

Website: www.ic.nc.gov

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 excluidos.

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 \$2,000.00.
- 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.

Para asistencia con entrenamiento de seguridad:

Director de Entrenamiento de Seguridad—(919) 807-2602 y safety@ic.nc.gov.



**NORTH CAROLINA INDUSTRIAL COMMISSION
1240 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-1240**

Página Oficial en Español: www.ic.nc.gov

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

IC File # _____

Emp. Code # _____

Carrier Code # _____

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 _____		
City State Zip _____			Insurance Carrier _____			Policy Number _____		
Home Telephone () - _____			Carrier's Address _____			City State Zip _____		
Social Security Number - - _____			Work Telephone () - _____			Carrier's Telephone Number () - _____		
Sex <input type="checkbox"/> M <input type="checkbox"/> F			Date of Birth / / _____			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: _____ on ____ / ____ / ____ at _____. 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: _____
Number of days out of work due to injury: _____
Medical treatment received? Yes No
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) <input type="checkbox"/> Employee, <input type="checkbox"/> Attorney, <input type="checkbox"/> Representative, or <input type="checkbox"/> 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: _____

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 \$2,000.00. 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 "1" 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.

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

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 _____
City _____	State _____	Zip _____	Insurance Carrier _____	Policy Number _____	
Home Telephone () - _____		Work Telephone () - _____		Carrier's Address _____	
- - _____		/ / _____		City _____ State _____ Zip _____	
Social Security Number _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	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 : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.					
5. Was employee paid for entire day _____ 6. Date disability began / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.					
7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____					
Person Injured	9. Occupation when injured _____				
	10. (a) Time employed by you _____ (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 _____		Signed by _____			Date Completed / / _____
		Official Title _____			

OSHA 301 Information:

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

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 cerciorarse 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.

STATEMENT OF DAYS WORKED AND EARNINGS OF INJURED EMPLOYEE

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 _____
 Address _____
 City _____ State _____ Zip _____
 Home Telephone () - _____
 Last 4 Digits of SSN **XXX-XX-** _____
 Sex M F
 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: \$ _____.

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.

By _____
Employer
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.

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

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 _____ Address _____ City _____ State _____ Zip _____ Home Telephone () - () - _____ Work Telephone () - () - _____	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 _____
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Employees are entitled to reimbursement of **\$0.545 per mile for travel for medical treatment, provided they travel 20 miles or more roundtrip, starting January 1, 2018.** 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 (actual, up to \$71.20 per day in-state or \$84.10 per day out-of-state):	Total Miles:
		Total meal expense (\$8.40 Breakfast, \$11.00 Lunch, and \$18.90 in-state or \$21.60 out-of-state Dinner):	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) **\$0.535** for 2017; (b) **\$0.54** for 2016; (c) **\$0.575** for 2015; (c) **\$0.56** for 2014; (e) **\$0.565** for 2013.

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.

SUPPLEMENTAL REPORT FOR FATAL ACCIDENTS
(FORM 19, EMPLOYER'S REPORT OF EMPLOYEE'S INJURY TO THE INDUSTRIAL COMMISSION, MUST ALSO BE SUBMITTED IN EVERY CASE)

IC File # _____

Emp. Code # _____

Carrier Code # _____

Employer FEIN _____

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. Code numbers assigned to each employer and carrier should be inserted before mailing.

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

Deceased 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 _____

XXX-XX- _____ Sex M F Date of Birth _____

Carrier's Telephone Number _____ Fax Number _____

1. Date of accident: _____ 2. Date of death: _____, 20 _____

3. Dependents, or if employee left no dependents, next of kin: (Indicate which are non-resident aliens)

	Name	Date of Birth	Relationship	Present Address
a.	_____	_____	_____	_____
b.	_____	_____	_____	_____
c.	_____	_____	_____	_____
d.	_____	_____	_____	_____
e.	_____	_____	_____	_____
f.	_____	_____	_____	_____

4. Immediate cause of death: _____

5. Amount of burial expenses authorized \$ _____

Signature of Employer or Carrier/Administrator _____ Title _____ Date _____

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
[HTTP://WWW.IC.NC.GOV/DOCFILING.HTML](http://www.ic.nc.gov/docfiling.html)