

APPLICATION TO TERMINATE OR SUSPEND PAYMENT OF COMPENSATION (G.S. § 97-18.1)

IC File #
Emp. Code #
Carrier Code #
Carrier File #

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, Insurance Carrier, Home Telephone, Work Telephone, Carrier's Address, City, State, Zip, Last 4 Digits of SSN, Sex, Date of Birth, Carrier's Telephone Number, Fax Number

IMPORTANT NOTICE TO EMPLOYEE: YOUR BENEFITS MAY BE STOPPED UNLESS YOU OBJECT IMMEDIATELY. IF YOU BELIEVE YOUR BENEFITS SHOULD NOT BE STOPPED, YOU MUST FILL OUT SECTION B. OF THIS FORM AND RETURN ONE COPY OF THIS FORM TO THE INDUSTRIAL COMMISSION.

SECTION A. To Be Completed By The Employer Or Carrier/Administrator:

- 1. Date of injury by accident: Date disability began:
2. Nature and extent of injury:
3. Number of weeks compensation paid: From: To:
4. Total amount of indemnity compensation paid to date: \$
5. Check applicable box(s):
6. Application is made to terminate or suspend compensation to the employee on the grounds that:
7. Check box if employee is in managed care.

In addition to filing this application and supporting documents with the Industrial Commission, I hereby certify that a copy of this application, together with all supporting documents, was served on the employee via Standard U. S. Mail, at:

(address) _____

(city, state, zip) _____

OR on the employee's attorney of record, if any, by e-mail or facsimile to:

(If e-mail, use the direct e-mail address for employee's attorney of record)

On the day of: _____ . The attached documents consist of _____ pages.
(date) (number)

SIGNATURE _____ PRINTED NAME _____ DATE _____

TELEPHONE NUMBER _____ DIRECT E-MAIL ADDRESS _____

TO BE COMPLETED BY THE EMPLOYEE

SECTION B. IF YOU THINK YOUR COMPENSATION SHOULD NOT BE STOPPED, YOU SHOULD COMPLETE THIS SECTION.

1. I do not think my compensation should be stopped because: _____

2. Enclose and specify the number of pages of documents the Industrial Commission should consider: _____

3. Provide a telephone number below at which you can be reached when the informal hearing is scheduled, from Monday through Friday between 8:00 a.m. and 5:00 p.m.. The Industrial Commission will notify you of the date and time of the hearing.

SIGNATURE OF EMPLOYEE OR ATTORNEY, IF REPRESENTED _____ PRINTED NAME _____ DATE _____

TELEPHONE NUMBER _____ DIRECT E-MAIL ADDRESS _____

If you need assistance in completing this form, you may contact the Industrial Commission at (800) 688-8349. You must contact the Office of the Executive Secretary at (919) 807-2657 to obtain an extension of time in which to submit medical records, or to obtain documents you have not been able to obtain.

EMPLOYEE: SEND A COPY YOUR RESPONSE ON THIS FORM AND SUPPORTING DOCUMENTS TO THE ATTORNEY IN SECTION A WHO FILED THIS FORM 24 APPLICATION ON BEHALF OF THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU ARE RECEIVING COMPENSATION. FILE A COPY WITH THE INDUSTRIAL COMMISSION AS INSTRUCTED AT THE BOTTOM OF THE FORM.

ATTORNEYS FILE VIA EDPF
[HTTP://WWW.IC.NC.GOV/DOCFILING.HTML](http://www.ic.nc.gov/docfiling.html)

EMPLOYEE FILING OPTIONS
E-MAIL TO: EXECSEC@IC.NC.GOV
FAX TO: (919) 715-0282
MAIL TO: NCIC - EXECUTIVE SECRETARY
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236

HELPLINE: (800) 688-8349
WEBSITE: [HTTP://WWW.IC.NC.GOV](http://www.ic.nc.gov)