

RESPONSE TO REQUEST THAT CLAIM BE ASSIGNED FOR HEARING

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

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

| | | | | | | | | |
|--------------------------------|-------------|-----------|---|-------------------------------------|--|-------------------------|-------------|-----------|
| Employee's Name _____ | | | Employer's Name _____ () _____ | | | Telephone Number _____ | | |
| Address _____ | | | Employer's Address _____ | | | City _____ | State _____ | Zip _____ |
| City _____ | State _____ | Zip _____ | Insurance Carrier _____ | | | | | |
| Home Telephone _____ () _____ | | | Work Telephone _____ () _____ | | | Carrier's Address _____ | | |
| Social Security Number _____ | | | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth _____ / _____ / _____ | | City _____ | State _____ | Zip _____ |
| | | | Carrier's Telephone Number _____ () _____ | | | Fax Number _____ | | |

In response to the Request for Hearing filed we have been unable to agree to the benefits claimed because (state reason with specificity):

DEFENDANT AGREES TO THE FOLLOWING:

Compensability Denied

Subject to Act: _____
Employment relationship: _____
Insurance coverage: _____
Date of injury: _____
Injury by accident _____
Arising out of and in the course of employment: _____
Occupational disease _____
Average weekly wage \$ _____
Other: _____

Compensability Admitted

Form 21 approved on: _____
Form 60 approved on: _____
Temp. total paid from: _____
to _____
Temp. partial paid from: _____
to _____
Perm. partial paid from: _____
to _____
for _____ % ppd of _____
Form 26 approved on: _____
Form 24 approved on: _____
Form 28B filed on: _____
Other: _____
Part of body: _____

City and county wherein injury occurred: _____
Estimated length of hearing: _____

MAIL TO: **NCIC – DOCKETS SECTION**
4336 MAIL SERVICE CENTER
RALEIGH, NC 27699-4336
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

Below is a list of names and addresses of all witnesses, including doctors, whose testimony is to be taken by the undersigned. Doctors outside the county of hearing are not required to attend this hearing.

| NAME | ADDRESS |
|-------|---------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

When a date of hearing is set, I respectfully request the Commission to send me signed subpoenas for my witnesses. When I receive these subpoenas, I will deliver them to the Sheriff of the county or counties in which each witness resides so that the subpoenas may be served.

(Signature) Title

(Address: street and number, city, state and zip)

(Date)

Note: A copy of this form must be sent to opposing parties. The original of this form must be sent to the Industrial Commission at the address below:

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