North Carolina Industrial Commission

IC File # _____

Emp. Code # _____

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)

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. 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- Last 4 Digits of SSN ☐ M ☐ F Sex / / 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

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 29