



Workers' Compensation Forms and Informational Material



*Forms provided by the North Carolina
Industrial Commission, myMatrixx, and
Craven County Schools*

Workers' Compensation

Explanation of Forms

*The **Form 19** should be used to record and report all on the job injuries. Be sure to fill out this form in its entirety.

*The **Form 18** is used by the employee to report an on-the-job injury to the North Carolina Industrial Commission. A blank Form 18 should be given to all employees when they have an injury, and a Form 19 is filed.

*The **Medical Treatment Request** should be used by the employee to accept or decline medical attention. This form clearly outlines which medical providers are available to treat an injured employee.

*The **Medical Release Authorization** should be signed by the employee and kept on file so that the insurance carrier may obtain medical records if the need arises.

*The **Procedural Acknowledgement Form** should be reviewed by employee, signed and a copy sent in along with the other paperwork.

*The **Incident Investigation Report** should be filled out by the person that investigates school incidents. The use of this form is critical so that the interest of all parties is protected should any doubt or concerns arise surrounding a claim.

*The **Form 25P** should be used for prescriptions only IF a participating pharmacy is not in your area or a participating pharmacy cannot fill the prescription. Some employees may have to get crutches, canes, etc., and pay out of pocket. The 25P will allow them to seek reimbursement for those charges. This form must be completed for reimbursement and may be given to the employee when they report the incident.

*The **Form 25T** should be used to record travel and seek reimbursement for mileage. Employees are entitled to mileage reimbursement should they have to travel beyond 20 miles (round trip) from point of origin for medical attention. This form must be completed for reimbursement and may be given to the employee when they report the incident.

Workers' Compensation Procedural Acknowledgement

1. **Use of Leave** – If you lose time away from work, you may choose one of the following:
 - Elect to take earned sick leave during the required waiting period and then go on Workers' Compensation leave and begin drawing Workers' Compensation weekly benefits.
 - Elect to go on Workers' Compensation leave with no pay for the required waiting period and then begin drawing Workers' Compensation weekly benefits.
 - Elect to supplement, if eligible, the Workers' Compensation weekly benefits with the use of earned sick leave in accordance with State Board of Education Worker's Compensation Policy.
Note: All elections involving the use of earned sick leave are subject to their availability.

2. **Waiting Period** – No compensation shall be allowed for the first seven days of disability resulting from an injury. If the injury results in disability of more than 21 days, (sick leave may be used for the first 7 days), then compensation will be allowed for the first seven days of disability.

3. **Workers' Compensation Rate** – The compensation rate is 66 2/3% of employee's average weekly wage subject to the minimum and maximum compensation rate. An employee's Average Week Wage is defined as earnings of employee in the employment in which he was working at the time of the injury during the period of 52 weeks immediately preceding the date of the injury divided by 52. But if employee did not earn wages for more than seven consecutive calendar days at one or more times during the 52 weeks, those weeks should not be included in the calculation. If you worked fewer than 52 weeks prior to injury, other means of calculation of the average weekly wage may be ordered by the Industrial Commission.

4. **Medical Services** – Employee must go to the doctors of the selected medical provider for workers' compensation treatment. If employee goes to a doctor of their own choosing for treatment, our workers' compensation carrier is not required to pay for this treatment if the doctor is not a designated medical provider.

5. **Nursing Services** – Nursing services are provided only at the request of the physician.
Note: Housekeeping services in your home and/or childcare are not considered nursing care.

6. **Prescription Drugs** – All prescription drugs must be obtained with the authorization from employee's workers' compensation insurance provider. In the event the employee is unable to receive the authorization, complete a **Form 25P**, attach the receipt and return both to the Workers' Compensation Administrator.

7. **Travel** – Employees are entitled to reimbursement for sick travel when the travel is medically necessary, and the mileage is 20 miles or more round trip at a rate established by the Industrial Commission. A **Form 25T** must be completed for reimbursement.

I have read the information above and understand the procedures that must be adhered to regarding my work-related injury.

Employee Signature

Date

Employer Signature

Date

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

IC File # _____

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 _____ |
| 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 / / |
| | 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 _____ Date Completed / /
Signed by _____ 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.

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 - - _____ | | Carrier's Telephone Number () - _____ | | Carrier's Fax Number () - _____ | |
| Sex <input type="checkbox"/> M <input type="checkbox"/> F | | Date of Birth / / _____ | | | |

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 \$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 "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.

Workers' Compensation Incident Investigation Report

Location: _____ Date of Report: _____

Name of Injured Person: _____ Phone Number: _____

Home Address _____

Date of Incident _____ Time of Incident _____

Witness(es) _____

How long has employee worked at this job? _____

On the date of the incident, what time did the employee report to work?: _____

Did the incident result in (check all that apply): Bodily Injury Property Damage

Treatment (check all that apply): First Aid Hospital Physician School Nurse

Describe location of incident:

Before the incident:

Describe anything that occurred prior to the incident. Note anything that was different, out of order, or not working properly. Follow the sequence of events in the order in which they happened until after the incident. Use additional sheets if necessary.

Intentional misrepresentation of a Workers' Compensation claim filed under North Carolina Workers' Compensation law can result in criminal prosecution.

Signature of Employee

Date

Signature of Employer

Date

Workers' Compensation Medical Treatment Request

I, _____, have been advised of the procedures for seeking medical treatment for my claimed work-related injury.

The medical providers for ALL work-related injuries are listed below. Making workers' compensation appointments with any other medical provider could cause the injured employee to be held liable for any related charges.

CCHC URGENT CARE
1040 Medical Park Avenue
New Bern, NC 28560
(252) 633-1678

If a referral to a medical specialist is needed, the medical provider requesting those services must contact the Workers' Compensation Specialist, CorVel or PMA for approval before the patient is treated.

- I do not need medical care at this time but if symptoms persist I may seek medical treatment.
- I wish to be treated for my claimed work-related injury.

Employee Signature _____

Date _____

Employer Signature _____

Date _____



AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I, the undersigned, authorize any physician, physician's assistant, or nurse who has attended me, or any hospital at which I have been confined, to furnish to any authorized representative of **SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.**, **PMA COMPANINES**, and the **WORKERS' COMPENSATION ADMINISTRATOR** at the Craven County Board of Education. All information which may be requested regarding my condition and/or treatment, and to allow them to examine and copy any radiographic pictures taken of me. I specifically authorize said physicians, nurses, and hospitals to communicate information by any means, including written or telephonic communication or by direct interview, whether I am present or notified of such communications, and I authorize, to initiate and conduct such communications whether I am present or have notice thereof.

A photo static or faxed copy of this waiver is to be given the same force and effect as the original.

Employee Signature: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

Date: _____

Claim Number: _____


Employer Signature: _____



State of North Carolina Department of Public Instruction Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

| | |
|--|--|
| |  PUBLIC SCHOOLS OF NORTH CAROLINA State Board of Education Department of Public Instruction |
| Employee Name: | |
| Group#: | 10602859 |
| Member ID (SSN): | |
| Date of Injury: | |
| Processor: | myMatrixx |
| Bin#: | 014211 |
| Day supply is limited to 30 days for a new injury. | |
| myMatrixx Help Desk: (877) 804-4900 | |

Employee:

State of North Carolina Department of Public Instruction has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:

Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

ITEMIZED STATEMENT OF CHARGES FOR DRUGS

IC File # _____

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

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 _____

| DATE | DRUG STORE | CITY | NAME OF DRUG & PRESCRIPTION NO. | PHYSICIAN | AMOUNT |
|--------------|------------|------|---------------------------------|-----------|-----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| TOTAL | | | | | \$ |

This is to certify that the drugs listed above were related to my workers' compensation injury. (Receipts must be furnished for carrier's file)

Employee signature

Carrier's approval

Reimburse employee

Yes no

Reimburse drug store

Yes no

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

EMPLOYER OR CARRIER/ADMINISTRATOR: DRUGS MAY BE REIMBURSED DIRECTLY TO THE EMPLOYEE OR DRUG STORE. IT IS NOT NECESSARY TO SUBMIT BILLS TO THE COMMISSION FOR APPROVAL. PAY AND RETAIN COPY IN CARRIER'S FILE.

ITEMIZED STATEMENT OF CHARGES FOR TRAVEL

IC File # _____

Emp. Code # _____

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

Carrier Code # _____

| | |
|----------------------------------|---|
| 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 _____ |
| | () - _____ Carrier's Telephone Number |
| | () - _____ Fax Number |

Employees are entitled to reimbursement of **\$0.585** per mile for travel for medical treatment, provided they travel 20 miles or more roundtrip, starting January 1, 2022. 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 6/30/21 (actual, up to \$71.20 per day for in-state or \$84.10 per day out-of-state). Total motel expense incurred on or after 7/1/21 (actual, up to \$78.90 per day for in-state or \$93.20 per day out-of-state). | Total Miles: |
| | | Total meal expense incurred through 6/30/21 (\$8.40 Breakfast, \$11.00 Lunch, and \$18.90 Dinner in-state or \$21.60 out-of-state). Total Meal expense incurred on or after 7/1/21 (\$9.00 Breakfast, \$11.80 Lunch, and \$20.50 Dinner in-state or \$23.30 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) \$0.56 for 2021; (b) \$0.575 for 2020; (c) \$0.58 for 2019; (d) \$0.545 for 2018; (e) \$0.535 for 2017.

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.