MAINE WORKERS' COMPENSATION

FORMS MANUAL

STATE OF MAINE

WORKERS' COMPENSATION BOARD

AUGUSTA, MAINE

JANUARY 1, 1995

STATE OF MAINE

WORKERS' COMPENSATION BOARD

CENTRAL OFFICE

State House Station #27
Augusta, Maine 04333-0027

Central Office - General Number	(207) 287-3751
Central Files Division	(207) 287-7062
Insurance Coverage Division	(207) 287-7074
Notice of Controversy (NOC)/Petitions Division	(207) 287-7066
Payments Division	(207) 287-7068

TDD (207) 287-6119 FAX (207) 287-7198

REGIONAL OFFICES

AUGUSTA
24 Stone Street
Augusta, Maine 04330-5220
(207) 287-2168
1-800-400-6854

BANGOR
106 Hogan Road
Bangor, Maine 04401-5640
(207) 941-4550
1-800-400-6856

CARIBOU
10 Washburn Avenue
Suite 110
Caribou, Maine 04736-2347
(207) 498-6428
1-800-400-6855

(Regional offices continued on next page.)

LEWISTON
140 Canal Street
Lewiston, Maine 04240-7761
(207) 783-5490
1-800-400-6857

PORTLAND
62 Elm Street
Portland, Maine 04101-3061
(207) 822-0840
1-800-400-6858

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This document can be provided in the following alternate formats:
Braille, large print, audiotape, audio cassette.

RESOURCES OFFERED BY THE MAINE WORKERS' COMPENSATION BOARD
(Copy Fee Schedule might apply.)

Maine Workers' Compensation Act of 1992, Title 39-A, M.R.S.A.

Maine Workers' Compensation Board Rules and Regulations

Maine Workers' Compensation Forms Manual

Maine Workers' Compensation Board 1993 Weekly Benefit Table

Maine Workers' Compensation Board 1994 Weekly Benefit Table

Maine Workers' Compensation Board 1995 Weekly Benefit Table

Maine Workers' Compensation Board Medical Fee Schedule

Facts About Maine Workers' Compensation Laws (an employee pamphlet)

Training workshops presented by Board staff

Maine Workers' Compensation Board Forms (First Reports of Injury, Wage Statements, etc.)

Call or write:

Workers' Compensation Board
Central Office
State House Station #27
Augusta, ME 04333-0027
Phone (207) 287-3751

TDD (207) 287-6119 FAX (207) 287-7198

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2. EMPLOYER FILE NUMBER:

3. EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27 AUGUSTA, MAINE 04333

4. WCB FILE NUMBER:

5. REASON FOR REPORT: CHECK ALL THAT APPLY
- LOST TIME - ONE OR MORE DAYS ☐
- MEDICAL/HEALTH CARE ☐
- OCCUPATIONAL DISEASE (Note Item 42 below) ☐
- CORRECT PRIOR REPORT ☐

EMPLOYER INFORMATION

6. EMPLOYER NAME:

7. EMPLOYER MAILING ADDRESS AND PHONE:

8. LOCATION IF DIFFERENT FROM MAILING ADDRESS:

9. NATURE OF BUSINESS:

10. NAME OF WC INSURER:

11. POLICY NUMBER:

EMPLOYEE INFORMATION

12. LAST NAME: | FIRST NAME: | M.I.: | 13. SOCIAL SECURITY NUMBER:

14. ADDRESS - NUMBER AND STREET:

15. CITY: | STATE: | ZIP:

16. HOME PHONE: | 17. DATE OF BIRTH: | 18. AGE: | 19. SEX: MALE ☐ FEMALE ☐

20. OCCUPATION:

21. DEPARTMENT:

22. DATE OF HIRE: | 23. DATE CURRENT DUTIES BEGAN: | 24. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? YES ☐ NO ☐

25. WEEKLY WAGE AT TIME OF INJURY:

INJURY OR EXPOSURE INFORMATION

26. DATE AND TIME OF INJURY: : AM ☐ PM ☐

27. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES SHOWN ABOVE? YES ☐ NO ☐

28. IF NO, PLACE WHERE INJURY OR EXPOSURE OCCURRED:

29. DESCRIBE THE EVENTS WHICH RESULTED IN THE INJURY OR DISEASE. (GIVE FULL DETAILS ON ALL FACTORS THAT LED OR CONTRIBUTED TO THE INJURY OR THE ONSET OF DISEASE.)

N
P
S
T
A

30. NAME THE OBJECT, SUBSTANCE, OR EXPOSURE WHICH DIRECTLY BROUGHT ABOUT THE INJURY OR DISEASE.

31. DESCRIBE THE INJURY OR DISEASE AND INDICATE PART OF BODY AFFECTED.

32. PHYSICIAN (NAME AND ADDRESS):

33.
- ☐ FIRST AID
- ☐ HOSPITAL
- ☐ EMERGENCY ROOM
- ☐ OUT-PATIENT

34. HOSPITAL (NAME AND ADDRESS):

35. DATE EMPLOYER NOTIFIED:

36. TIME EMPLOYEE WORKDAY BEGAN: AM ☐ PM ☐

37. DID EMPLOYEE LOSE ONE OR MORE DAYS WORK? YES ☐ NO ☐ IF NO, SKIP BOXES 38, 39 40 AND 41

38. WAS EMPLOYEE PAID FOR 1/2 DAY OR MORE ON DAY OF INJURY? YES ☐ NO ☐

39. DATE INCAPACITY BEGAN:

40. HAS EMPLOYEE RETURNED TO WORK? YES ☐ NO ☐ IF YES, GIVE DATE:

41. DID EMPLOYEE DIE? YES ☐ NO ☐ IF YES, GIVE DATE:

42. FOR OCUPATIONAL DISEASE
DATE OF LAST EXPOSURE:
DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED:

PREPARER INFORMATION

43. PREPARER NAME AND TITLE (TYPE OR PRINT):

SIGNATURE (FORM MUST BE SIGNED):

DATE:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-1 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

Within seven days after the employer receives notice or knowledge of an employee injury, the employer or insurer (which can sometimes be one and the same) must file an Employer's First Report if the employee requires the services of a health care provider or loses a day's work. The employer retains a copy of this form, one copy goes to the insurer, and one copy goes to the employee. A copy goes to the Board only if the injury causes the employee to lose one day or more of work.

If the employer or insurer disputes a medical bill on a claim for which a First Report was never filed with the Board, the employer or insurer attaches the Board's copy of the First Report to the Notice of Controversy.

A First Report must be filed with the Board if the employee dies as a result of a job-related injury or if the employee dies at the work site, regardless of the reason for death.

The Employer's First Report of Occupational Injury or Disease, WCB-1, is a four-part form.

The medical only First Report is distributed as follows:

Copy 1 retained by preparer
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

The lost time (one day or more) First Report is distributed as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING
EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

Employer Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time the First Report is filed, enter it here. The Board will record it for reference.

2. Employer File Number
   This box is provided for use by the employer.

3. Employer Unemployment Insurance Account Number (UIAN)
   The Workers' Compensation Board uses the Unemployment Insurance Account Number (UIAN) to identify employers. This 10-digit number is assigned by the Maine Department of Labor to all employers who are liable for contributions for unemployment insurance. If the employer is not liable for contributions to unemployment insurance, the employer will not have a UIAN and should, therefore, call the Coverage Division of the Workers' Compensation Board to ask for assignment of an identification number.

4. WCB File Number
   This number is assigned by the Board and will be filled in by the Board.

5. Reason for Report
   Check any box that applies. If the employee lost one or more days of work, check "Lost Time - One or More Days". If medical or health care was required, whether or not one or more days were lost, check "Medical/Health Care". If you are filing because of damage to eyeglasses or prosthetic devices, check "Medical/Health Care". If you are filing because of an occupational disease, enter the date of last exposure in Box 26 and Box 42. If the preparer needs to correct a prior report, take the following action:

   a. Copy the incorrect First Report.
   b. Circle the incorrect data.
   c. Write the correct information in contrasting color.
   d. Check "Correct Prior Report" in Box 5.

6. Employer Name
   Enter the employer name as it appears on the employer's workers' compensation insurance policy.

7. Employer Mailing Address and Phone
   Enter the address where the employer receives mail. If the employer has multiple addresses, use the address for the place of business where the injured employee was assigned. Enter the employer phone number, including area code.

8. Location, If Different from Mailing Address
   Enter the employer business location if it differs from the employer mailing address. If the employer has multiple locations, use the address for the place of business where the injured employee was assigned.

9. Nature of Business
   Enter the type of business in which the employer is engaged, e.g., construction, well drilling, health care, etc.

10. Name of WC Insurer
    Enter the name of the employer's workers' compensation insurance company. If the employer is self-insured or group self-insured, indicate this and provide the name of the third-party administrator if there is one.

11. Policy Number
    Enter the employer's workers' compensation insurance policy number. If the employer is self-insured or group self-insured, skip this box.

Employee Information

12. Name
    Enter employee's name (last name, first name, middle initial).

13. Social Security Number
    Enter employee's social security number.

14. Address - Number and Street
    Enter employee's mailing address.

15. City, State, Zip
    Enter employee's city, state, and zip code mailing address. If the employee lives in Canada, enter the Province and Canadian zip code.

16. Home Phone
    Enter employee's home telephone number, including area code.

17. Date of Birth
    Enter employee's date of birth.

18. Age
    Enter employee's age.

19. Sex
    Enter employee's sex.

20. Occupation
    Enter employee's occupation, e.g., legal secretary, file clerk, computer programmer, truck driver, etc. Describe what the employee does as clearly as possible. Avoid using jargon.

21. Department
    Enter the name of the department where the employee is regularly assigned.

22. Date of Hire
    Enter date employee was hired.

23. Date Current Duties Began
    Enter date employee began performing the job held when the injury or exposure occurred.

24. Does Employee Work for Another Employer?
    Check "Yes" or "No".

25. Weekly Wage at Time of Injury
    Enter the weekly wage the employee was receiving at the time of the injury.

Injury or Exposure Information

26. Date and Time of Injury
    Enter the date and time of the injury. Enter the time in the form of hours and minutes, and check AM or PM. For example, if the injury occurred at 1:30 in the morning, enter "1:30" and check AM. If the injury occurred at noon or midnight, enter the word "noon" or "midnight".

27. Did Injury or Exposure Occur on Employer's Premises Shown Above?
    Answer "Yes" if the injury or exposure occurred at the address listed in either Box 7 or Box 8. Answer "No" if the injury or exposure did not occur at the address listed in either Box 7 or Box 8.

28. If No, Place Where Injury or Exposure Occurred
    If Box 27 is checked "No", enter the street address, city, state, and zip code where the injury occurred. If this is not possible, describe the geographical location where the injury or exposure occurred, e.g., "near mile marker 81, southbound lane of Maine Turnpike".

29. Describe the Events Which Resulted in the Injury or Disease.

    Enter what happened and how it happened. Name any objects or substances involved, and tell how they were involved. Give full details about all factors that led or contributed to the injury. This information will assist the insurer in properly handling the claim. This information also will be used to code safety information at the Maine Department of Labor to help prevent similar injuries in the future.

30. Name the Object, Substance, or Exposure Which Directly Brought About the Injury or Disease.

    Examples include the machine or object the employee struck or that struck the employee, the vapor or poison the employee inhaled or swallowed, the chemical or radiation that irritated the employee's skin, or, in cases of strains or hernias, the object that was lifted, pulled, or pushed.

31. Describe the Injury or Disease and Indicate Part of Body Affected.

    When specifying a part of body, be sure to indicate whether "left" or "right". When injury involves fingers or toes, use the numbers one through five to describe the body part. (One is the thumb or big toe; five is the little finger or little toe.) Be as descriptive as possible about the severity of the injury.

32. Physician (Name and Address)

    Enter the name and address of the physician, if any, who provided initial medical treatment.

33. Type of Care Required

    Check any box describing the type of initial care the injured employee received. "First Aid" means the employee received care on the employer's premises. "Hospital" means the employee was admitted to the hospital. "Emergency Room" means the employee received care in the emergency room of a hospital. "Out-patient" means the employee received care at a health care provider, clinic, or out-patient department of a hospital.

34. Hospital (Name and Address)

    If initial treatment was provided at a hospital, enter the name and address of the hospital.

35. Date Employer Notified

    Enter the date the employer knew about the occupational injury or disease. **NOTE: It is not necessary for the employee to tell the employer about the injury for the employer to have notice of the injury.** For example, if the employer or a supervisor saw the injury occur or its occurrence was brought to the employer's attention, the employer is considered to have notice or knowledge of the injury at that time.

36. Time Employee Workday Began

Enter the normal work starting time for the injured employee. Enter the time in the form of hours and minutes, and check AM or PM. For example, if the injury occurred at eleven o'clock at night, enter "11:00" and check "PM". If the workday began at noon or midnight, enter the word "noon" or midnight".

37. Did Employee Lose One or More Day's Work?

If the employee lost one or more days of work, check "Yes". If the employee did not lose one or more days of work, check "No" and skip Boxes 38 through 41.

38. Was Employee Paid for 1/2 Day or More on Day of Injury?

Check "Yes" or "No". (When the employee is paid 1/2 day or more wages on the date of injury, the date of injury will not be considered a day of incapacity.)

39. Date Incapacity Began

If the employee lost less than one day's work, skip this box. Otherwise, enter the date of the first day the employee lost time from work due to the injury.

40. Has Employee Returned to Work?

If the employee lost less than one day's work, skip this box. If the employee lost more than one day and has returned to work, check "Yes" and enter the date the employee returned. If the employee lost more than one day and has not returned to work, check "No".

41. Did Employee Die?

If the employee died as a result of the injury or exposure, or died at the workplace regardless of the reason for death, check "Yes" and enter the date of death. If the employee's injury did not result in death, check "No".

42. For Occupational Disease

For occupational disease cases, enter the date of last exposure to the condition(s) that caused the disease and the date the disease was first diagnosed by a physician as occupationally related.

Preparer Information

43. Preparer Name and Title, Signature, and Date

Enter the preparer's name and title. Sign the Report. Enter the date the report was prepared.

WAGE STATEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE: 14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER. YES ☐ NO ☐

19. DOES THE EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? YES ☐ NO ☐

20. WEEK 52 IS THE WEEK BEFORE THE INJURY

WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			52		
17			35			21. TOTAL EARNINGS		$
18			36			22. GROSS AVERAGE WEEKLY WAGE		$

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-2 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF WAGE STATEMENT, WCB-2

The employer or insurer (which can sometimes be one and the same) must file a Wage Statement with the Workers' Compensation Board within 30 days after the initial indemnity payment (Box 21 of the first Memorandum of Payment, WCB-3).

The Wage Statement is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING WAGE STATEMENT, WCB-2

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time the Wage Statement is filed, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it appears on the employer's workers' compensation insurance policy.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurance company. If the employer is self-insured or group self-insured, indicate this and provide the name of the third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number

   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name

   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name

   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.

    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street

    Enter employee's mailing address.

12. City

    Enter city of employee's mailing address.

13. State

    Enter state of employee's mailing address.

14. Zip

    Enter zip code of employee's mailing address.

15. Home Phone Number

    Enter employee's home telephone number, including area code.

16. Date of Injury

    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury

    Enter a complete description of the injury.

18. Does Employee Work for Another Employer?

    Check "Yes" or "No". If "Yes", the employer for whom the employee worked at the time of the injury is required to file the Wage Statement(s), WCB-2, from the employee's other employer(s).

19. Does the employee receive fringe benefits that may stop while on Workers' Compensation?
Check "Yes" or "No". If the employee receives any fringe or other benefit paid by the employer that does not continue during the disability, that amount must be included for purposes of determining the employee's average weekly wage. (If the employee's 80 percent net average weekly wage is less than two-thirds of the statewide average weekly wage, the employee is entitled to inclusion of fringe benefits. This inclusion, however, should not increase the employee's rate beyond two-thirds of the statewide average weekly wage.)

Wage Information

20. Weekly Wages
Enter the "week ending" date and "gross earnings" for the 52 weeks preceding the injury. Week 52 is the week prior to the injury. Week 1 is one year preceding the injury.

A **legible** copy of the employer's record of payments containing the same or equivalent information is acceptable in place of Box 20.

If the employee did not work for the employer for 52 weeks preceding the injury, refer to Section 102 (4) of the Act to determine the proper information to file.

21. Total Earnings
Add weeks 1 through 52. When the employer's record of payments is used to provide the information requested in Box 20, the "Total Earnings" from that record of payments must be entered in Box 21.

22. Gross Average Weekly Wage
Enter the average weekly wage. (Compute this amount by dividing the total earnings by the number of weeks worked, or by 52 if the employee is a seasonal worker.)

Preparer Information

23. Preparer Name and Title
Type or print the preparer's name and title.

24. Telephone Number
Enter the preparer's telephone number, including area code.

25. Date Mailed
Enter the actual date this document is mailed.

SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

EMPLOYER/INSURER COMPLETES BOXES 1 TO 17

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

EMPLOYEE COMPLETES BOXES 18 TO 21

18.

FEDERAL TAX FILING STATUS

- ☐ SINGLE
- ☐ MARRIED/JOINT
- ☐ SINGLE/HEAD OF HOUSEHOLD
- ☐ MARRIED/SEPARATE

19.

DEPENDENT(S)

DEPENDENT NAME(S) (IF NONE, SO STATE)	RELATIONSHIP (i.e., spouse, daughter, son)	DATE OF BIRTH	SOCIAL SECURITY NUMBER (IF NONE, SO STATE)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

20. EMPLOYEE SIGNATURE:	21. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-2A (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT, WCB-2A

For injuries occurring on or after January 1, 1993, the employer or insurer (which can sometimes be one and the same) must file a Schedule of Dependent(s) and Filing Status Statement with the Workers' Compensation Board within 30 days after the initial indemnity payment (Box 21 of the first Memorandum of Payment, WCB-3). **NOTE: The Schedule of Dependent(s) and Filing Status Statement should be attached to the Wage Statement before mailing to the Workers' Compensation Board.**

The Schedule of Dependent(s) and Filing Status Statement is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT, WCB-2A

Boxes 1 through 17 are completed by the employer/insurer

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Schedule of Dependent(s) and Filing Status Statement, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurance company. If the employer is self-insured or group self-insured, indicate this and provide the name of the third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

Boxes 18 through 21 are completed by the employee

18. Federal Tax Filing Status

    The employee checks the appropriate box based on the employee's Federal Income Tax Return. The filing status is determined according to IRS regulations for the year preceding the injury.

19. Dependent(s)

    List all members of the employee's household whom the employee is able to claim as dependents on the Federal Income Tax Return. The Board will accept this form without the social security number(s) of dependent(s).

20. Employee Signature

    The employee signs this section of the form. This information is for use by the employer/insurer. The Board will accept unsigned forms completed by the employer/insurer if the employee refuses to complete this section.

21. Date

    The employee enters the date this section of the form was prepared.

MEMORANDUM OF PAYMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

NOTICE TO EMPLOYEE

18. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS UPON PAYMENT OF A LOST TIME WORK-RELATED INJURY.

YOUR CLAIM IS:

☐ ACCEPTED.

☐ VOLUNTARY PAYMENT PENDING INVESTIGATION.

19. REASON FOR PAYMENT:

☐ INITIAL WEEKLY COMPENSATION
☐ RESTORATION OF WEEKLY COMPENSATION
☐ IMPAIRMENT
☐ OTHER (EXPLAIN) _____

20. DATE OF INCAPACITY:	21. DATE OF PAYMENT:	22. PERIOD COVERED BY PAYMENT: FROM (DATE): TO (DATE):	
23. CURRENT WEEKLY COMPENSATION RATE: ☐ TOTAL ☐ PARTIAL $	24. AVERAGE WEEKLY WAGE: $	25. AMOUNT OF PAYMENT: $	26. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): ☐ YES ☐ NO

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
10 WASHBURN AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

27. PREPARER NAME AND TITLE (TYPE OR PRINT):	28. TELEPHONE NUMBER:	29. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-3 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF MEMORANDUM OF PAYMENT, WCB-3

The employer or insurer (which can sometimes be one and the same) must file a Memorandum of Payment (often referred to as a "MOP") to report the start of weekly compensation payments pursuant to 39-A M.R.S.A. §205 (7) and Board Rule 1.1.

The Memorandum of Payment is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING MEMORANDUM OF PAYMENT, WCB-3

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Memorandum of Payment, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurance company. If the employer is self-insured or group self-insured, indicate this and provide the name of the third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number

   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name

   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name

   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.

    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street

    Enter employee's mailing address.

12. City

    Enter city of employee's mailing address.

13. State

    Enter state of employee's mailing address.

14. Zip

    Enter zip code of employee's mailing address.

15. Home Phone Number

    Enter employee's home telephone number, including area code.

16. Date of Injury

    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury

    Enter a complete description of the injury.

Notice to Employee

18. Your Claim Is

    If the insurer plans to investigate the claim, check the "Voluntary Payment Pending Investigation" Box. Otherwise, check the "Accepted" Box.

19. Reason For Payment

    Check the box that describes the reason for the payment. If "Other" is checked, enter a brief description of the type of payment.

20. Date of Incapacity

    Enter the date of the first day (partial or full) lost from work for the current incapacity period.

21. Date of Payment

    Enter the date payment was first made to the employee for the current incapacity.

22. Period Covered by Payment

    From (Date): To (Date):

    Enter the inclusive dates covered by the payment. Make no entries here if the payment was for permanent impairment or occupational loss. **NOTE: Enter only one period of incapacity in Box 22 per form.**

23. Current Weekly Compensation Rate

    Check the appropriate box to indicate whether payment is for total or partial incapacity. Also enter the dollar amount of the current compensation rate. Rates are based on the law in effect at the time of the injury.

24. Average Weekly Wage

    Enter the Average Weekly Wage. This amount should be the same as the average weekly wage listed on the Wage Statement. **Do not enter the escalated Average Weekly Wage.**

25. Amount of Payment

    Enter the amount (in dollars and cents) of weekly compensation payment(s) made for this period of incapacity.

26. Does Employee Work for Another Employer?

    Check "Yes" or "No". If the employee works for another employer, check "Yes" and provide the name(s). **NOTE: The employer for whom the employee worked at the time of the injury is required to file the Wage Statement(s) from the employee's other employer(s).**

Preparer Information

27. Preparer Name and Title
    Type or print the preparer's name and title.

28. Telephone Number
    Enter the preparer's telephone number, including area code.

29. Date Mailed
    Enter the date this form is mailed.

DISCONTINUANCE OR MODIFICATION OF COMPENSATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP: / 15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

DISCONTINUANCE

18. REASON FOR DISCONTINUANCE:

- ☐ RETURNED TO WORK FOR SAME EMPLOYER §205 (9) (A)
- ☐ INCREASED EARNINGS §205 (9) (A)
- ☐ BOARD DECISION
- ☐ OTHER (EXPLAIN) _____

19. PERIOD OF INCAPACITY: FROM (DATE): TO (RETURN DATE):	20. WEEKLY COMPENSATION RATE:	21. AMOUNT PAID:	22. DATE OF FINAL PAYMENT:
	$	$	

MODIFICATION

23. REASON FOR MODIFICATION:

- ☐ RETURNED TO WORK FOR SAME EMPLOYER §205 (9) (A)
- ☐ DECREASED EARNINGS
- ☐ AVERAGE WEEKLY WAGE ESTABLISHED
- ☐ INCREASED EARNINGS §205 (9) (A)
- ☐ COST OF LIVING ADJUSTMENTS
- ☐ OTHER (EXPLAIN) _____

24. OLD COMPENSATION RATE:	25. NEW COMPENSATION RATE:	26. EFFECTIVE DATE OF MODIFICATION:
$	$	

27. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
10 WASHBURN AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

28. PREPARER NAME AND TITLE (TYPE OR PRINT):	29. TELEPHONE NUMBER:	30. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-4 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

The employer or insurer (which can sometimes be one and the same) files this form for such reasons as the discontinuance or modification of compensation pursuant to 39-A M.R.S.A. §205 (9) (A), a Board decision, cost-of-living adjustments, Social Security offsets, and unemployment compensation offsets. **NOTE: This form is not used for discontinuances or reductions under 39-A M.R.S.A. §205 (9) (B).**

The Discontinuance or Modification of Compensation is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Discontinuance or Modification of Compensation, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

Discontinuance

18. Reason for Discontinuance
    Check the box that describes the reason for discontinuing compensation. If "Other" is checked, provide a brief explanation for the discontinuance.

19. Period of Incapacity
    From (Date):
    Enter the date incapacity began. This date should be the same as Box 20 of the Memorandum of Payment, WCB-3, for the current incapacity period. **NOTE: Enter only one period of incapacity in Box 19 per form.**

    To (Return Date): Enter the date this incapacity ended. This is the date the employee returned to work.

20. Weekly Compensation Rate
    Enter the weekly compensation rate used for this period of incapacity.

21. Amount Paid
    Enter the total amount (in dollars and cents) of weekly compensation paid for this period of incapacity.

22. Date of Final Payment
    Enter the date of the last weekly compensation payment for this period of incapacity.

Modification

23. Reason for Modification
    Check the box that describes the reason for modification. If "Other" is checked, provide a brief explanation for the modification.

24. Old Compensation Rate
    Enter the compensation rate (in dollars and cents, unless varying rates are paid) prior to the change.

25. New Compensation Rate
    Enter the new compensation rate (in dollars and cents, unless varying rates are paid).

26. Effective Date of Modification
    Enter the date the rate change took effect.

27. Comments
    Use this area to enter any information that might be pertinent to the claim.

Preparer Information

28. Preparer Name and Title
    Type or print the preparer's name and title.

29. Telephone Number
    Enter the preparer's telephone number, including area code.

30. Date Mailed
    Enter the date this form is mailed.

CERTIFICATE OF
DISCONTINUANCE OR REDUCTION OF COMPENSATION

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

NOTICE TO EMPLOYEE

YOUR WEEKLY COMPENSATION BENEFITS WILL BE DISCONTINUED OR REDUCED 21 DAYS FROM THE DATE THIS CERTIFICATE WAS MAILED BASED ON THE ATTACHED INFORMATION. IF YOU DISAGREE WITH THIS ACTION, YOU ARE ENTITLED TO FILE A PETITION FOR REVIEW AND TO REQUEST THE PROVISIONAL REINSTATEMENT OF YOUR BENEFITS. YOUR PETITION AND REQUEST SHOULD BE MAILED TO THE ABOVE WORKERS' COMPENSATION BOARD ADDRESS.

18. REASON FOR DISCONTINUANCE OR REDUCTION OF BENEFITS:

DISCONTINUANCE

19. PERIOD OF INCAPACITY: FROM (DATE): TO (EFFECTIVE DATE OF DISCONTINUANCE):	20. WEEKLY COMPENSATION RATE:	21. COMPENSATION PAYMENT TO DATE OF CERTIFICATE	22. COMPENSATION TO BE PAID FOR 21 DAY PERIOD:
	$	$	$

REDUCTION

23. OLD COMPENSATION RATE:	24. NEW COMPENSATION RATE:	25. EFFECTIVE DATE OF REDUCTION:
$	$	

26. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
10 WASHBURN AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

27. PREPARER NAME AND TITLE (TYPE OR PRINT):	28. TELEPHONE NUMBER:	29. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-8 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

The employer or insurer (which can sometimes be one and the same) must file a Certificate of Discontinuance or Reduction of Compensation when compensation is discontinued or reduced pursuant to 39-A M.R.S.A. §205 (9) (B)(1).

The Certificate of Discontinuance or Reduction of Compensation is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Certificate of Discontinuance or Reduction of Compensation, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

18. Reason for Discontinuance or Reduction of Benefits

Enter the reason for discontinuing or reducing compensation, and attach any information that the employer, insurer, or self-insured used to support this action.

Discontinuance

19. Period of Incapacity

From (Date):

Enter the date incapacity began. This date should be the same as Box 20 of the Memorandum of Payment, WCB-3, for the current incapacity period. **NOTE: Enter only one period of incapacity in Box 19 per form.**

To (Effective Date of Discontinuance):

Enter the date payment for the incapacity will end (21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, Box 29). Do not count the day the Certificate of Discontinuance or Reduction of Compensation is mailed to calculate the 21-day period.

EXAMPLE: May 5 (Date Certificate is mailed, Box 29)
+ 21 (days)
= May 26 (Effective date of discontinuance or reduction)

20. Weekly Compensation Rate

Enter the weekly compensation rate (in dollars and cents, unless varying rates are paid) used for this period of incapacity.

21. Compensation Payment to Date of Certificate

Enter the total amount of weekly compensation (in dollars and cents) due to date (date the Certificate of Discontinuance or Reduction of Compensation is mailed) for the current incapacity period.

22. Compensation to be Paid for 21 Day Period

Enter the total amount of weekly compensation (in dollars and cents) to be paid for the 21-day notice period.

Reduction

23. Old Compensation Rate

Enter the compensation rate (in dollars and cents, unless varying rates are paid) prior to change.

24. New Compensation Rate

Enter the new compensation rate (in dollars and cents, unless varying rates are paid).

25. Effective Date of Reduction
    Enter the date the change will take effect. (See example for Box 19.)

26. Comments
    Use this box to enter any information that might be pertinent to the claim.

Preparer Information

27. Preparer Name and Title
    Type or print the preparer's name and title.

28. Telephone Number
    Enter the preparer's telephone number, including area code.

29. Date Mailed
    Enter the date the Certificate of Discontinuance or Reduction of Compensation was mailed. This date should be 21 days prior to the date shown in Box 19 (Effective Date of Discontinuance).

The Certificate of Discontinuance or Reduction of Compensation should be sent by certified mail to both the Board and to the employee.

NOTICE OF CONTROVERSY

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYEE

YOUR EMPLOYER/INSURER IS DISPUTING YOUR CLAIM OR A PART OF IT. THE REASON FOR THE DISPUTE IS GIVEN BELOW. YOU WILL BE CONTACTED BY A CLAIMS RESOLUTION SPECIALIST FROM THE BOARD TO ASSIST IN RESOLVING THIS DISPUTE.

REASON FOR DISPUTE (EXPLAIN):

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

CARIBOU
10 WASHBURN AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

19. PREPARER NAME AND TITLE (TYPE OR PRINT):	20. TELEPHONE NUMBER:	21. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-9 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF NOTICE OF CONTROVERSY, WCB-9

The employer or insurer (which can sometimes be one and the same) must file a Notice of Controversy (often referred to as a "NOC") to report the controverting of a claim for weekly compensation or other benefit(s).

The Notice of Controversy is a four-part form. The distribution is as follows::

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING NOTICE OF CONTROVERSY, WCB-9

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Notice of Controversy, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number

   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name

   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name

   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.

    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street

    Enter employee's mailing address.

12. City

    Enter city of employee's mailing address.

13. State

    Enter state of employee's mailing address.

14. Zip

    Enter zip code of employee's mailing address.

15. Home Phone Number

    Enter employee's home telephone number, including area code.

16. Date of Injury

    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury

    Enter a complete description of the injury.

18. Notice to Employee

    Enter the specific items(s) and reason(s) for the Notice of Controversy.

Preparer Information

19. Preparer Name and Title
    Type or print the preparer's name and title.

20. Telephone Number
    Enter the preparer's telephone number, including area code.

21. Date Mailed
    Enter the date the Notice of Controversy is mailed.

LUMP SUM SETTLEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE	14. ZIP: / 15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

18. TYPE OF SETTLEMENT:

☐ STRUCTURED SETTLEMENT (ATTACH DOCUMENTATION)

☐ LUMP SUM SETTLEMENT TOTAL VALUE OF SETTLEMENT $_____

19. COMMENTS:

20. PREPARER NAME AND TITLE (TYPE OR PRINT):	21. TELEPHONE NUMBER:	22. DATE:

RELEASE

23. **EMPLOYEE/DEPENDENT:**

I AM THE PERSON ENTITLED TO WORKERS' COMPENSATION BENEFITS ON ACCOUNT OF THIS INJURY OR DEATH. I HAVE READ THIS WORKSHEET AND ALL ATTACHMENTS. WHEN I RECEIVE THE AMOUNT SHOWN ABOVE AND THIS SETTLEMENT IS APPROVED BY THE HEARING OFFICER, I RELEASE THE EMPLOYER AND INSURER NAMED ABOVE FROM ALL FURTHER LIABILITY FOR THIS INJURY. I CONSENT TO THE SETTLEMENT.

_____ EMPLOYEE/DEPENDENT SIGNATURE

_____ ATTORNEY SIGNATURE

_____ DATE

EMPLOYER/INSURER:

THE EMPLOYER CONSENTS TO THE SETTLEMENT: YES ☐ NO ☐ _____ SIGNATURE _____ DATE

THE INSURER CONSENTS TO THE SETTLEMENT: YES ☐ NO ☐ _____ SIGNATURE _____ DATE

DECISION

24. THE REQUESTED SETTLEMENT *(IS/IS NOT)* (CIRCLE ONE) APPROVED. THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT THE SUM OF $_____ IN A LUMP SUM SETTLEMENT ACCORDING TO THE WORKERS' COMPENSATION ACT. THE EMPLOYER/INSURER IS ORDERED TO PAY ALL OUTSTANDING COMPENSATION OBLIGATIONS INCURRED PRIOR TO THIS SETTLEMENT BY THE EMPLOYEE/DEPENDENT. THE EMPLOYER/INSURER IS ORDERED TO PAY THE ATTORNEY OF THE EMPLOYEE/DEPENDENT A FEE OF $_____.

ALL PENDING PETITIONS BASED ON THIS CLAIM ARE HEREBY DISMISSED.

_____ HEARING OFFICER SIGNATURE

_____ DATE

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-10 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF LUMP SUM SETTLEMENT, WCB-10

The employer, insurer, third-party administrator, employee, and/or attorney files the Lump Sum Settlement form to request approval of a lump sum settlement.

The Lump Sum Settlement is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING LUMP SUM SETTLEMENT, WCB-10

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Lump Sum Settlement, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

18. Type of Settlement
    Check the box that describes the type of settlement. If the settlement is structured, attach the appropriate documentation. If the settlement is a straight lump sum, enter the total value.

19. Comments
    Use this box to enter any information that might be pertinent to the claim.

Preparer Information

20. Preparer Name and Title
    Type or print the preparer's name and title.

21. Telephone Number
    Enter the preparer's telephone number, including area code.

22. Date
    Enter the date this form is completed.

Release

23. This box is for the employee/dependent, attorney(s), insurer, third-party administrator, and employer to sign and date, whether or not they agree with the requested lump sum settlement.

Decision

24. This box is to be used only by the Hearing Officer.

STATEMENT OF COMPENSATION PAID

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:	7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:	

INSURER: REPORT CUMULATIVE AMOUNTS PAID IN BOX 19 EVERY 6 MONTHS AS AN INTERIM REPORT IF CASE ACTIVITY IS ONGOING OR AS A FINAL REPORT IF CASE IS CLOSED. SEE RULE 8.1.

18.

☐ INTERIM REPORT (ONGOING PAYMENTS) ☐ FINAL REPORT

NOTICE TO EMPLOYEE

THIS REPORT IS A PAYMENT SUMMARY OF YOUR CLAIM. PLEASE KEEP FOR YOUR RECORDS.

PAYMENT SUMMARY

19. LIST CUMULATIVE TOTALS:

MEDICAL	$	DEATH BENEFIT/FUNERAL EXPENSE	$
WEEKLY COMPENSATION	$	LEGAL EXPENSE (EMPLOYEE RELATED)	$
PERMANENT IMPAIRMENT	$	LEGAL EXPENSE (EMPLOYER RELATED)	$
REHABILITATION EXPENSE	$	OTHER PAYMENTS	$
LUMP SUM SETTLEMENT	$		
		TOTAL PAID:	$

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
10 WASHINGTON AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

20. PREPARER NAME AND TITLE (TYPE OR PRINT):	21. TELEPHONE NUMBER:	22. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-11 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF STATEMENT OF COMPENSATION PAID, WCB-11

The employer or insurer (which can sometimes be one and the same) must file a Statement of Compensation Paid to report the cumulative amount paid on lost time only cases every six months from the date of initial indemnity payment (Box 21 of the first Memorandum of Payment, WCB-3) and every six months thereafter, or as a Final Report if the case is closed.

The Statement of Compensation Paid is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING STATEMENT OF COMPENSATION PAID, WCB-11

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Statement of Compensation Paid, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

18. Interim/Final Report
    Check the box that describes the type of report.

19. List Cumulative Totals

Enter cumulative payments for each category. **Do not reduce these totals by the amount of any recovered deductible.**

EXAMPLE: The following has been paid on a claim:

Doctor bills: $ 500.00
Hospital bills: 1,000.00
Weekly comp: 2.000.00

A $1,000 deductible has been recovered from the employer.

The amounts shown in Box 19 are as follows:

Medical: $1,500.00
Weekly comp: $2,000.00

After entering the cumulative totals, also enter the total amount paid for all categories.

Preparer Information

20. Preparer Name and Title
    Type or print the preparer's name and title.

21. Telephone Number
    Enter the preparer's telephone number, including area code.

22. Date Mailed
    Enter the date this form is mailed.

EMPLOYER'S SUPPLEMENTAL REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

NOTICE TO EMPLOYER

THIS REPORT IS USED **ONLY** WHEN THE EMPLOYEE LOSES A DAY OR MORE FROM WORK THAT DOES NOT RESULT IN THE FILING OF A MEMORANDUM OF PAYMENT, A NOTICE OF CONTROVERSY OR IF BOXES 39 AND 40 OF THE FIRST REPORT, WCB-1, ARE COMPLETED OR CORRECTED AS APPLICABLE. THE EMPLOYER SHALL FILE THIS REPORT TO THE BOARD ADDRESS LISTED ABOVE WITHIN SEVEN DAYS OF THE EMPLOYEE'S RETURN TO WORK (SEE RULE 8.16).

18. ON WHAT DATE DID THIS EMPLOYEE BEGIN LOSING TIME FROM WORK? MONTH DAY YEAR HOUR AM ☐ PM ☐

19. ON WHAT DATE DID THIS EMPLOYEE RETURN TO WORK? MONTH DAY YEAR HOUR AM ☐ PM ☐

20. IS THE INJURED EMPLOYEE EARNING THE SAME WEEKLY WAGES AS BEFORE THE INJURY? YES ☐ NO ☐

21. DID THIS EMPLOYEE RETURN TO WORK WITH A DIFFERENT EMPLOYER? IF YES, GIVE NAME(S): YES ☐ NO ☐

22. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
10 WASHBURN AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. DATE MAILED:

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-12 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD (2) EMPLOYER (3) INSURER (4) FILE

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF EMPLOYER'S SUPPLEMENTAL REPORT, WCB-12

The employer files an Employer's Supplemental Report **only** when the employee loses a day or more from work that does not result in the filing of a Memorandum of Payment, a Notice of Controversy, or the applicable completion or correction of Boxes 39 and 40 of the Employer's First Report of Occupational Injury or Disease, WCB-1. The employer files the Employer's Supplemental Report with the Board within seven days of the employee's return to work.

The Employer's Supplemental Report is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING EMPLOYER'S SUPPLEMENTAL REPORT, WCB-12

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Employer's Supplemental Report, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number

   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name

   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name

   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.

    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street

    Enter employee's mailing address.

12. City

    Enter city of employee's mailing address.

13. State

    Enter state of employee's mailing address.

14. Zip

    Enter zip code of employee's mailing address.

15. Home Phone Number

    Enter employee's home telephone number, including area code.

16. Date of Injury

    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury

    Enter a complete description of the injury.

Notice to Employer

18. On What Date Did This Employee Begin Losing Time from Work?
    Enter the month, day, year, and hour (including AM or PM) when the employee actually began losing time for the current incapacity period.

19. On What Date Did This Employee Return to Work?
    Enter the month, day, year, and hour (including AM or PM) when the employee returned to work.

20. Is the Injured Employee Earning the Same Weekly Wages As Before the Injury?
    Check either "Yes" or "No".

21. Did This Employee Return to Work with a Different Employer?
    Check either "Yes" or "No". If "Yes", give the name(s) of the new employer(s).

22. Comments.
    Enter any information that might be pertinent to the claim.

Preparer Information

23. Preparer Name and Title
    Type or print the preparer's name and title.

24. Telephone Number
    Enter the preparer's telephone number, including area code.

25. Date Mailed
    Enter the date this form is mailed.

EMPLOYMENT STATUS REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY THE EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYEE

THIS REPORT IS DUE 90 DAYS AFTER THE DATE OF INJURY, AND EVERY 90 DAYS THEREAFTER, PURSUANT TO 39-A M.R.S.A. § 308 (2) . ANY EMPLOYER REQUESTING A QUARTERLY REPORT MUST PROVIDE THE EMPLOYEE WITH THIS REPORT AT LEAST 15 DAYS PRIOR TO THE DATE ON WHICH IT IS DUE. **FAILURE TO COMPLETE AND RETURN THIS REPORT MAY RESULT IN THE DISCONTINUANCE OF YOUR WORKERS' COMPENSATION BENEFITS.**

THIS REPORT IS DUE:_____, 19_____

THIS REPORT COVERS THE PERIOD FROM: _____,19 ___ TO _____ ,19 ___

THIS COMPLETED REPORT SHOULD BE RETURNED TO: _____

_____

_____

PART 2 (COMPLETED BY THE EMPLOYEE)

19.

A. DID YOU WORK OR PERFORM ANY SERVICES FOR PAY OR OTHER BENEFIT DURING THE PERIOD STATED IN THE ABOVE SECTION? YES ☐ NO ☐

B. IF YES, COMPLETE THE FOLLOWING AND **ATTACH VERIFICATION OF INCOME** (USE REVERSE SIDE IF NECESSARY):

EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

C. WHAT TYPE(S) OF WORK DID YOU PERFORM IN THIS EMPLOYMENT?

D. DATES EMPLOYED: FROM: _____ , 19___ TO: _____, 19___

E. ARE YOU STILL EMPLOYED? YES ☐ NO ☐

20. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ _____

EMPLOYEE SIGNATURE DATE

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-230 (8/94)

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF EMPLOYMENT STATUS REPORT, WCB-230

The employer or insurer (which can sometimes be one and the same) may send the Employment Status Report to the employee for completion of Boxes 19 and 20. If the employer/insurer chooses to do this, the report is due 90 days after the date of injury and every 90 days thereafter. The employee must receive the request for completion of Boxes 19 and 20 at least 15 days before its due date.

The Employment Status Report is a three-part form. The distribution is as follows:

Copy 1 to the Employee
Copy 2 to the Insurer
Copy 3 to the Employer

The Board does not receive a copy of this report.

INSTRUCTIONS FOR COMPLETING EMPLOYMENT STATUS REPORT, WCB-230

Boxes 1 through 18 are completed by the employer/insurer

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Employment Status Report, enter it here.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

18. Notice to Employee

Enter the date the completed report is due, the periods covered, and where to return the completed report (employer or insurer name and address).

Boxes 19A through 20 are completed by the employee

19A. Did You Work or Perform Any Services for Pay or Other Benefit During the Period Stated in the Above Section?

Check either "Yes" or "No".

19B. If "Yes" is checked, complete this section with the name, address, and telephone number(s) of each new employer(s). (Use reverse side of report if necessary.) **Attach verification of income from each new employer.**

19C. What Type(s) of Work Did You Perform in This Employment?

Indicate the type of work done for each new employer.

19D. Dates Employed

Indicate the dates employed with each new employer.

19E. Are You Still Employed?

Check either "Yes" or "No".

20. Sign and date this form to certify that the information is truthful and accurate.

EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY THE EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THIS REPORT IS SENT TO THE EMPLOYEE WHEN FILING THE MEMORANDUM OF PAYMENT PURSUANT TO 39-A M.R.S.A. § 205(7).

19.

NOTICE TO EMPLOYEE

IF YOU RETURN TO WORK WITH A NEW EMPLOYER, COMPLETE BOX 20 AND RETURN THIS REPORT TO THE BOARD ADDRESS LISTED ABOVE, THE EMPLOYER LISTED IN BOX 2 AND THE INSURER LISTED IN BOX 4 WITHIN 7 DAYS PURSUANT TO 39-A M.R.S.A. § 308(1).

FAILURE TO COMPLETE AND RETURN THIS REPORT MAY RESULT IN THE DISCONTINUANCE OF YOUR WORKERS' COMPENSATION BENEFITS.

PART 2 (COMPLETED BY THE EMPLOYEE)

20. COMPLETE THE FOLLOWING INFORMATION (USE REVERSE SIDE IF NECESSARY):

A. NEW EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

B. DATE OF HIRE: _____

C. ATTACH VERIFICATION OF INCOME OR LIST ANTICIPATED INCOME:

D. COMMENTS:

21. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.

_____ EMPLOYEE SIGNATURE

_____ DATE

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB-231 (8/94) DISTRIBUTION: COPY (1) WORKERS' COMPENSATION BOARD, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

The employer or insurer (which can sometimes be one and the same) mails the Employee's Return to Work Report to the employee when filing the Memorandum of Payment, WCB-3 pursuant to 39-A M.R.S.A.§205 (7). The employee completes Boxes 20 and 21 of this form and files it with the employer (Box 2) and the insurer (Box 4) within seven days of his or her return to work with a new or different employer.

The Employee's Return to Work Report is a four-part form. The distribution is as follows:

Copy 1 to the Workers' Compensation Board
Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

Boxes 1 through 17 are completed by the employer/insurer

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Employee's Return to Work Report, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number
   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name
   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street
    Enter employee's mailing address.

12. City
    Enter city of employee's mailing address.

13. State
    Enter state of employee's mailing address.

14. Zip
    Enter zip code of employee's mailing address.

15. Home Phone Number
    Enter employee's home telephone number, including area code.

16. Date of Injury
    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a complete description of the injury.

Notice to Employer Insurer

18. This section notifies the employer/insurer when to send this form to the employee.

Notice to Employee

19. This section notifies the employee of his or her responsibilities.

Boxes 20 and 21 are completed by the employee

20. Complete this section, supplying the following information:
    A. Name, address, and telephone number(s) of each new employer
    B. Date(s) of hire
    C. Attach verification of income or list anticipated income with each new employer.
    D. Use this space to provide any comments.

21. Sign and date this form to certify that the information is truthful and accurate.

REQUEST FOR EXPEDITED PROCEEDING

STATE OF MAINE
WORKERS' COMPENSATION BOARD
STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER:		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE NUMBER:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. A. ☐ REQUEST FOR PROVISIONAL ORDER AND EXPEDITED PROCEEDING PURSUANT TO 39-A M.R.S.A. § 205(9)(E) AND RULE 1.3.

B. ☐ REQUEST FOR EXPEDITED PROCEEDING PURSUANT TO 39-A M.R.S.A. §315.

C. ☐ REQUEST FOR EXPEDITED PROCEEDING BASED ON EXTREME FINANCIAL HARDSHIP. EXPLANATION:

ATTACH THIS REQUEST TO THE FRONT OF THE APPROPRIATE PETITION AND SUPPORTING DOCUMENTS.

19. WHEREFORE, I HEREBY REQUEST AN EXPEDITED PROCEEDING.

_____ _____

SIGNATURE OF REQUESTING PARTY DATE

NAME AND ADDRESS OF ATTORNEY (IF ANY):

REPRESENTING (CHECK ONE):

☐ EMPLOYEE ☐ EMPLOYER

ASSISTANCE IS AVAILABLE AT THE BOARD'S REGIONAL OFFICES:

AUGUSTA
24 STONE ST.
AUGUSTA, ME 04330-5220
287-2168
1-800-400-6854

BANGOR
106 HOGAN RD.
BANGOR, ME 04401-5640
941-4550
1-800-400-6856

CARIBOU
10 WASHBURN AVE.
SUITE 110
CARIBOU, ME 04736-2347
498-6428
1-800-400-6855

LEWISTON
140 CANAL ST.
LEWISTON, ME 04240-7711
783-5490
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME 04101-3061
822-0840
1-800-400-6858

REPORTING REQUIREMENTS FOR AND DISTRIBUTION OF REQUEST FOR EXPEDITED PROCEEDING, WCB-250

This form is used to request a Provisional Order and/or an Expedited Proceeding. The employer, insurer, third-party administrator, employee, or attorney attaches this form to the front of the appropriate petition(s) and supporting documents and sends the complete packet to the Board's Central Office in Augusta.

The Request for Expedited Proceeding is a one-part form.

INSTRUCTIONS FOR COMPLETING REQUEST FOR EXPEDITED PROCEEDING, WCB-250

Identifying Information

1. Insurer File Number
   This box is provided for use by the insurer. If the insurer file number is known at the time of filing the Request for Expedited Proceeding, enter it here. The Board will record it for reference.

2. Employer Name
   Enter the employer name as it was entered in Box 6 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

4. Insurer Name
   Enter the name of the employer's workers' compensation insurer, self-insured, or third-party administrator if there is one.

5. Insurer Mailing Address
   Enter the insurer, self-insured, or third-party administrator's mailing address.

6. Social Security Number
   Enter the employee's social security number.

7. WCB File Number

   If the preparer knows this number, enter it here. Doing so will speed up processing this form.

8. Employee Last Name

   Enter the employee's last name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name

   Enter the employee's first name as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.

    Enter the employee's middle initial as entered in Box 12 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address-Number and Street

    Enter employee's mailing address.

12. City

    Enter city of employee's mailing address.

13. State

    Enter state of employee's mailing address.

14. Zip

    Enter zip code of employee's mailing address.

15. Home Phone Number

    Enter employee's home telephone number, including area code.

16. Date of Injury

    Enter the date of injury. This date should be the same as Box 26 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury

    Enter a complete description of the injury.

Request for Provisional Order and Expedited Proceeding

18. Check the appropriate box.

Request an Expedited Proceeding

19. Sign and date the form.
    Provide the name and mailing address of the preparer's attorney (if any).
    Check the appropriate box to show who is represented.

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