STATE OF MAINE

WORKERS' COMPENSATION BOARD

OFFICE OF MONITORING, AUDIT AND ENFORCEMENT

FORMS MANUAL

EFFECTIVE
JANUARY 1, 2013

Compiled and issued by the Maine Workers' Compensation Board (Board). Printed under appropriation number 014 90C 2005 012.

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with any of these forms, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or Maine Relay 711.

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STATE OF MAINE
WORKERS' COMPENSATION BOARD

CENTRAL OFFICE

27 State House Station
Augusta, Maine 04333-0027
(207) 287-3751
1-888-801-9087
Maine Relay 711
FAX (207) 287-7198

Abuse Investigation Unit	(207) 287-7065
Claims Management Unit	(207) 287-2002
FAX (**for Claims Management forms only)**	(207) 287-5895
Office of Monitoring, Audit and Enforcement	(207) 287-7067

REGIONAL OFFICES

AUGUSTA

24 Stone Street, Suite 102
Augusta, Maine 04330-5220
(207) 287-2308
1-800-400-6854

BANGOR

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

CARIBOU

One Vaughn Place
43 Hatch Drive, Suite 110
Caribou, Maine 04736-2347
(207) 498-6428
1-800-400-6855

LEWISTON

36 Mollison Way
Lewiston, Maine 04240-5811
(207) 753-7700
1-800-400-6857

PORTLAND

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

OTHER RESOURCES OFFERED BY THE MAINE WORKERS' COMPENSATION BOARD

(Available from Central Office)
(Fee Schedule may apply)

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

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

Maine Workers' Compensation Board Rules and Regulations

Maine Workers' Compensation Board 1993-2012 Weekly Benefit Tables

Maine Workers' Compensation Board Medical Fee Schedule

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

Training workshops presented by Board staff (call Office of Monitoring, Audit & Enforcement 287-7067)

MAINE WORKERS' COMPENSATION BOARD FORMS REFERENCE GUIDE

BOARD FORM		STATUTES	RULES	FILING REQUIREMENTS
WCB-1	First Report of Injury	§303	1.7 3.1 3.4 8.13 8.16	Filed electronically within 7 days notice/knowledge of incapacity.
WCB-2	Wage Statement	§153(4) §205(8) §303	1.7	Filed within 30 days notice/knowledge of a claim for compensation.
WCB-2A	Schedule of Dependents and Filing Status Statement	§303	1.7 8.9	Filed within 30 days notice/knowledge of a claim for compensation for dates of injury prior to 1/1/13.
WCB-2B	Fringe Benefits Worksheet	§303	1.7 8.9	Filed within 30 days notice/knowledge of a claim for compensation.
WCB-3	Memorandum of Payment	§153(1)(B) §205(7)	1.1 1.7 8.12	Filed within 14 days notice/knowledge of a claim for incapacity or death benefits.
WCB-4	Discontinuance or Modification of Compensation	§205(9)(A)	1.7 8.11 8.12	Filed within 14 days after benefits are reduced or discontinued pursuant to 39-A M.R.S.A. §205(9)(A).
WCB-4A	Consent Between Employer and Employee		8.18	Filed when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification or discontinuance in ongoing weekly incapacity benefits.
WCB-6	Certificate Authorizing Release of Benefit Information	§221(5)		Used to request information about payments made to an injured employee from the Social Security Administration or from an Employee Benefit Plan.
WCB-7	Certificate Authorizing Release of Unemployment Information	§220		Used to request information about unemployment payments made to an injured employee.
WCB-8	Certificate of Discontinuance or Reduction of Compensation	§205(9)(B)(1)	1.7 8.15	Filed via certified mail no later than 21 days prior to the effective date of the discontinuance or reduction of benefits. pursuant to 39-A M.R.S.A. §205(9)(B)(1).
WCB-9	Notice of Controversy	§313(1)	1.1 1.7 3.4 8.2 8.12	Filed electronically within 14 days of a claim for incapacity or death benefits.

MAINE WORKERS' COMPENSATION BOARD FORMS REFERENCE GUIDE

BOARD FORM				
WCB-10	Lump Sum Settlement	§352	1.7	Filed to request approval of a lump sum settlement.
WCB-11	Statement of Compensation Paid		1.7 8.1 8.12	Filed within 195 days from the date of injury when indemnity benefits are paid and annually on the anniversary date of the injury subsequent to that. Final report when no further benefits are anticipated.
WCB-220	Limited Certificate Authorizing Written Release of Medical/Health Care Information	§208(1)	12.18	Used to obtain medical records and information, pre-existing and subsequent to the workplace injury.
WCB-230	Employment Status Report	§308(2)	1.8	Used to obtain employment information from an employee receiving compensation under the Act who has not returned to that person's previous employment.
WCB-231	Employee's Return to Work Report	§308(1)	1.7 8.17	Filed within 7 days of the person's return to work.
WCB-231A	Employee's Return to Work Report	§205(9)(B) §308(1)	1.7 8.15	This report is sent to the employee with the Certificate of Discontinuance or Reduction of Compensation or the Petition for Review.

Effective 1/1/2013

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ▪ LOST TIME - ONE OR MORE DAYS

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

3. ▪ LOST EARNINGS BUT NO LOST TIME

4. ▪ MEDICAL/HEALTH CARE

5. ▪ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. ▪ OCCUPATIONAL DISEASE

6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY

6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. ▪ CORRECT PRIOR REPORT

7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY

7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O. BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ▪ YES ▪ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) INSURER **THIRD PARTY ADMINISTRATOR (TPA)** **SELF-ADMINISTERED EMPLOYER**

19. INSURANCE/TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER: XXX-XX-	32. GENDER: ▪ MALE ▪ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ▪ YES ▪ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ▪ YES ▪ NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ▪ YES ▪ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ▪ YES ▪ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ▪ YES ▪ NO	55. HEALTH CARE PROVIDER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OF PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.

WCB-1 (eff. 1/1/13)

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

General Reporting Requirements

When any employee has reported to an employer under this Act any injury arising out of and in the course of the employee's employment that has caused the employee to lose a day's work, or when the employer has knowledge of any such injury, the employer shall report the injury to the board within 7 days after the employer receives notice or has knowledge of the injury. See Section 303.

The definition of a day for the purposes of filing a FROI under Section 303 is the wages in an employee's regular workday. Wages in an employee's regular workday is the amount equivalent to a day's wages for those who earn the same amount each workday, regardless of the duration of such person's employment. For all others, wages in an employee's regular workday is determined by dividing the pre-tax wages earned by the employee during the four (4) full work week period immediately preceding the date of injury by the number of days worked during the same four (4) full work week period. In the event that an employee has worked for less that the four (4) full work week period preceding the date of injury, wages in an employee's regular workday is determined by dividing the pre-tax wages earned by the number of days worked. See Rule 3.1.

Lost Wages: The FROI must be filed* within seven (7) days after the employer's notice or knowledge that an employee has actually lost wages in an amount equivalent to that sum which would have been earned in a regular workday.

Lost Time: If the employee has physical limitations due to the injury and loses consecutive hours equal to a regular workday because the employer cannot accommodate those restrictions, a FROI must be filed* within seven (7) days after an employer's notice or knowledge that an employee has actually lost hours equal to a regular workday regardless of actual wage loss.

When an employee loses a day or more from work that does not result in the filing of a Memorandum of Payment or a Notice of Controversy, the employer/insurer shall notify the Board of the employee's return to work date, if the date was not included on the original First Report, by filing* an 02 First Report using the IAIABC Claims Release 3 format. The employee's return to work date shall be filed within seven (7) days of the employee's return to work. See Rule 8.16.

Death: 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/insurer must file* a FROI.

* accepted EDI transaction, with or without errors (TE or TA only)

Medical Only: The employer/insurer must complete a FROI within seven (7) days of notice or knowledge of an employee injury that requires the services of a health care provider, but there is no obligation to file it with the Board unless the injury later causes the employee to lose a day's work. If the employer/insurer disputes a medical bill on a claim for which a FROI was never filed, the employer/insurer must file* the FROI.

Two Injuries on Same Day at Same Employer: In the event that an employee alleges two separate injuries on the same date while working for the same employer, only one FROI may be filed via EDI. The other FROI must be sent to the Board (in accordance with the guidelines established above) via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

Please call 207-287-7197 before sending the paper FROI so that it does not get rejected.

* accepted EDI transaction, with or without errors (TE or TA only)

EDI Reporting Requirements

Unless a waiver has been granted, effective July 1, 2005, all FROIs (see above exception for two injuries on same day at same employer) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC/DN0002). MTC/DN0002 is a code that identifies the type of FROI transaction:

MTC	Definition
00	Original: The original/initial FROI, including the re-transmission of a FROI that was rejected due to a critical error, or a FROI that was previously cancelled.
01	Cancel: Cancel/delete FROI from the Board's system. The original/initial FROI was sent in error. The jurisdiction claim number/WCBN is mandatory for this transaction.
02	Change/Update: Change/update FROI. The jurisdiction claim number/WCBN is mandatory for this transaction.
CO	Correction: Correct transaction reported on the AKC as TE (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction.
04	Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board.
AQ	Acquired Claim: Report that a new claim administrator has acquired the claim. The jurisdiction claim number/WCBN is mandatory for this transaction.
AU	Acquired/Unallocated Claim: The equivalent of a FROI 00 filed by new claim administrator.
UR	Upon Request: Submitted in response to a specific request. If the Board receives a subsequent report of injury (MOP, Petition) for an employee for a date of injury that is not in the Board's system, a letter will be sent to the claim administrator requesting that a FROI UR be sent. There is no other circumstance in which a FROI UR should be sent to the Board. The jurisdiction claim number/WCBN is mandatory for this transaction.

* accepted EDI transaction, with or without errors (TE or TA only)

Each transaction requires a Claim Type Code (DN0074). DN0074 is a code representing the current classification of the claim:

DN0074	**Definition**
M	Medical Only.
I	Lost Time/Indemnity.
N	Notification Only.
B	Became Medical Only.
L	Became Lost Time/Indemnity.

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

DN0111	**Definition**
HD	Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the claim administrator's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A FROI is not considered filed with the Board until it receives a TA or TE code on the AKC.

Corrections

Changes and corrections to FROIs must be filed[*] via EDI. Please note the important difference between a change (MTC 02) and a correction (MTC CO), as outlined above.

[*] accepted EDI transaction, with or without errors (TE or TA only)

Distribution
WCB-1 (1/02) shall be mailed to the employee and the employer within 24 hours after the FROI is sent to the Board.

Closure (required for all lost time FROIs)
Closure of the FROI is required if a FROI is or should have been filed with the Board under Section 303. See Rule 8.16. Closure occurs when one of the following actions is taken:

1) Return to Work: Where days lost is less than or equal to 7 days, the actual return-to-work date must be reported to the Board within 7 days of the employee's return to work by sending a FROI 02 transaction. This step is unnecessary if the actual return-to-work date was previously reported on the original/initial FROI.

2) Indemnity Payment: Where the initial claim for indemnity benefits is paid, a Memorandum of Payment must be sent to the Board on or before the 14th day payment is due under Section 205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where sent via standard mail).

3) Controversy: Where the initial claim for indemnity benefits is in dispute, a Notice of Controversy must be filed* on or before the 14th day payment is due under Section 205(2).

Form Filing Violations
Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

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

For instructional purposes, this Forms Manual indicates the WCB-1 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist claim administrators with electronic filing and paper distribution of FROIs. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any mandatory fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a TR on the AKC. A TR on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any expected fields are missing, incomplete or incorrect, the FROI will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC CO using the jurisdiction claim number/WCBN provided in the acknowledgement report.

* accepted EDI transaction, with or without errors (TE or TA only)

1. WCB File Number (if known): **(Assigned for FROI 00, FROI 04, and FROI AU; Mandatory for FROI 01, FROI 02, FROI CO, FROI AQ and FROI UR) (DN5 – JURISDICTION CLAIM NUMBER)**
   Enter the file number assigned by the Board to identify this claim**.**

1a. OSHA 300 Case Number (if applicable): **(Not on the IAIABC format).**

2a. ☐ Lost Time - One or More Days

Check this box if the employee has lost a day or more **(DN74 - CLAIM TYPE CODE = I or L)**. If this box is checked, then 2b must be completed.

2b. Was Employee Paid for ½ Day or More on Day of Injury? ☐Yes ☐ No
(Not on the IAIABC format) Check either Yes or No.

3. ☐ Lost Earnings But No Lost Time
Check this box if the employee's earnings have been reduced because of the effects of this injury, but the employee has not lost a day's work or more **(Not on the IAIABC format).**

4. ☐ Medical/Health Care
Check this box if the employee's injury has required the services of a healthcare provider **(DN74 - CLAIM TYPE CODE=B or M)**.

5. ☐ Fatality Date of Death:
Check this box if the employee has died as a result of a job-related injury or if the employee died at the work site (DN146 – DEATH RESULT OF INJURY CODE=Y or U). If this box is checked, the date of the employee's death is mandatory **(DN57 – EMPLOYEE DATE OF DEATH).**

6a. ☐ Occupational Disease
Check this box if the employee's occupational injury, illness or death is one of the following: loss of hearing, silicosis, asbestos-related disease, or exposure to radioactive properties. **(DN290 – TYPE OF LOSS CODE=02)**. **If this box is checked, then 6b and 6c must be completed.**

6b. Date of Last Exposure: **Do not complete this box if 6a is not checked.**
If box 6a is checked, enter the last date that the employee was exposed to the cause or condition from which the occupational disease arose **(DN31 – DATE OF INURY).**

6c. Date of Diagnosis as Occupationally Related: **Do not complete this box if 6a is not checked.)** If box 6a is checked, enter the date the injury, illness, or death was first diagnosed by a physician as being occupationally related. **(Not on the IAIABC format)**

7a. ☐ Correct Prior Report
Check this box if you are correcting a prior report **(DN2 – MAINTENANCE TYPE CODE= 02 or CO) If this box is checked, then 7b and 7c must be completed.**

7b. Date of Correction: **Do not complete this box if 7a is not checked.**
If box 7a is checked, enter the date that this form was corrected
(DN3 – MAINTENANCE TYPE CODE DATE)

7c. Date correction Sent to WCB: **Do not complete this box if 7a is not checked.**
If box 7a is checked, enter the date that the corrected copy of this form was sent to the Board **(DN3 – MAINTENANCE TYPE CODE DATE)**

8. State Employer Unemployment Insurance Account Number (UIAN): **(Mandatory) (DN329 – EMPLOYER UI NUMBER)**
Enter the UIAN of the employer where the employee was employed at the time of the injury. 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 must, therefore, call the Coverage Division of the Board (287-7092) to ask for an identification number.

9. Federal Employer Identification Number (FEIN): **(Expected) (DN16 - EMPLOYER FEIN)**
Enter the FEIN of the employer where the employee was employed at the time of the injury. This 9-digit number is assigned by the Federal Internal Revenue Service (IRS) to report all monies paid to the IRS. In some cases, this is the same as the employer's social security number.

10. Employer Name: **(Mandatory) (DN18 – EMPLOYER NAME)**
Enter the legal name of the employer.

11. Street/P.O. Box Mailing Address:
DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected)
DN169 – EMPLOYER MAILING SECONDARY ADDRESS (Expected Conditional)
Enter the primary and secondary (if applicable) mailing addresses of the employer.

12. City: **(Expected) (DN165 – EMPLOYER MAILING CITY)**
Enter the city of the employer's mailing address.

13. State: **(Expected) (DN170 – EMPLOYER MAILING STATE CODE)**
Enter the state of the employer's mailing address.

14. Zip: **(Expected) (DN167 – EMPLOYER MAILING POSTAL CODE)**
Enter the postal code of the employer's mailing address.

15. Telephone Number: **(If Available) (DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER)**
Enter the phone number of the employer, including area code.

16. Primary Business Performed by Employer Where Injury Occurred: **(If Available) (DN25 – INDUSTRY CODE)**

Enter the code representing the nature of the employer's business which is contained in the industrial classification manual published by the Federal Office of Management and Budget.

17. Employer Location If Different from Mailing Address:

DN019 – EMPLOYER PHYSICAL PRIMARY ADDRESS (Expected Conditional)
DN020 – EMPLOYER PHYSICAL SECONDARY ADDRESS (If Available)
DN021 – EMPLOYER PHYSICAL CITY (Expected Conditional)
DN022 – EMPLOYER PHYSICAL STATE CODE (Expected Conditional)
DN023 – EMPLOYER PHYSICAL POSTAL CODE (Expected)
DN164 – EMPLOYER PHYSICAL COUNTRY CODE (Expected Conditional)
Values: see http://www.iaiabc.org/

Enter the employer's physical location if it differs from the employer's mailing address. If the employer has multiple locations, use the address for the place of business where the injured employee was working at the time of the injury.

18. Did Injury or Exposure Occur on Employer's Premises? **(Mandatory) (DN249 – ACCIDENT PREMISES CODE)** ☐ Yes **(DN249=E)** ☐ No **(DN249=L or X)**

If No, Then Give Name and Physical Address of the Employer Where the Employee was Injured or Exposed: **(Expected Conditional)**

DN120 – ACCIDENT SITE ORGANIZATION NAME
DN119 – ACCIDENT SITE LOCATION NARRATIVE (location not post office identifiable)
DN122 – ACCIDENT SITE STREET
DN121 – ACCIDENT SITE CITY
DN123 – ACCIDENT SITE STATE CODE
DN033 – ACCIDENT SITE POSTAL CODE
DN118 – ACCIDENT SITE COUNTY/PARISH
DN280 – ACCIDENT SITE COUNTRY CODE Values: see http://www.iaiabc.org/

If the employee was not injured on the employer's premises, then enter the name and physical address of the site where the employee was injured or exposed.

☐ **Insurer** ☐ **Third-Party Administrator (TPA)** ☐ **Self-Administered Employer**
Check the box that describes the legal entity adjusting the claim.

19. Insurance/TPA Company Name: **(Expected) (DN7 – INSURER NAME/DN188 – CLAIM ADMINISTRATOR NAME)**

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim.

20. Policy Number: **(Not Applicable) (DN28 – POLICY NUMBER)**

Enter the policy number identifying the coverage policy in effect for the claim.

21. Insurer File Number: **(Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)**
Enter an identifier for a specific claim within the claim administrator's processing system.

22. Street/P.O. Box Mailing Address:
DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected)
DN11 – CLAIM ADMINISTRATOR SECONDARY ADDRESS (If Available)
Enter the primary and secondary (if applicable) addresses of the claim administrator.

23. City: **(Expected) (DN12 – CLAIM ADMINISTRATOR CITY)**
Enter the city of the claim administrator.

24. State: **(Expected) (DN13 - CLAIM ADMINISTRATOR STATE)**
Enter the state of the claim administrator.

25. Zip: **(Mandatory) (DN14 - CLAIM ADMINISTRATOR POSTAL CODE)**
Enter the postal code of the claim administrator.

26. Telephone number: **(Not on the IAIABC format)**
Enter the telephone number, including area code, of the claim administrator.

27. Last Name:
(DN43 – EMPLOYEE LAST NAME) (Mandatory)
(DN255 – EMPLOYEE LAST NAME SUFFIX) (If Available)
Enter the employee's legally recognized last name and last name suffix.

28. First Name: **(Mandatory) - (DN44 – EMPLOYEE FIRST NAME)**
Enter the employee's first name.

29. MI: **(If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)**
Enter the employee's middle initial.

30. Home Phone #: **(If Available) (DN51 – EMPLOYEE PHONE NUMBER)**
Enter the employee's home telephone number, including area code.

31. Social Security Number: **(Mandatory)**
Enter the employee's ID #.
Values: DN042 – EMPLOYEE SSN (DN270=S)
DN152 – EMPLOYEE EMPLOYMENT VISA (DN270=E)
DN153 – EMPLOYEE GREEN CARD (DN270=G)
DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION (DN270=A)
DN156 – EMPLOYEE PASSPORT NUMBER (DN270=P)

32. Gender: ☐Male ☐Female **(Expected) (DN53 – EMPLOYEE GENDER CODE=M or F)**
Check either M for Male or F for Female to identify the employee's gender (check neither if DN53=U).

33. Street/P.O. Box Mailing Address:
DN46 – EMPLOYEE MAILING PRIMARY ADDRESS (Expected)
DN47 – EMPLOYE MAILING SECONDARY ADDRESS (If Available)
Enter the primary and secondary mailing addresses of the employee.

34. City: **(Expected) – (DN48 – EMPLOYEE MAILING CITY)**
Enter the city of the employee's mailing address.

35. State: **(Expected) – (DN49 – EMPLOYEE MAILING STATE CODE)**
Enter the state of the employee's mailing address.

36. Zip: **(Expected) – (DN50 – EMPLOYEE MAILING POSTAL CODE)**
Enter the postal code of the employee's mailing address.

37. Date of Birth: **(Expected) – (DN52 – EMPLOYEE DATE OF BIRTH)**
Enter the date employee was born.

38. Occupation/Job Title: **(Expected) (DN60 - OCCUPATION DESCRIPTION)**
Enter the employee's primary occupation at the time of injury, e.g., legal secretary, file clerk, computer programmer, truck driver, etc. Describe what the employee does as clearly as possible. Avoid using jargon.

39. Date of Hire: **(Expected) – (DN61 – EMPLOYEE DATE OF HIRE)**
Enter the date the employee began his/her employment with the employer under whose coverage the claim is being filed. If there have been multiple periods of employment with the same employer, this would be the beginning date of the current employment period.

40. Weekly Wage at Time of Injury **(If Available) (DN62 – WAGE)**
Enter the weekly wage the employee was receiving at the time of the injury.

41. Does Employee Work for Another Employer? ☐Yes ☐No **(Not on the IAIABC format)**
Check either Yes or No.

If Yes, Give Name and Address:
Enter the name and address of any other employer(s) with whom the employee was employed at the time of the injury.

42. Date of Injury or Illness: **(Mandatory) (DN31 – DATE OF INJURY)**
For traumatic injury, enter the date on which the work-related accident occurred. For occupational disease or work-related cumulative injury, enter the date of last injurious exposure to the cause or substance creating the condition.

Date Employer Notified: **(Expected) (DN40 – DATE EMPLOYER HAD KNOWLEDGE OF THE INJURY)**

Enter the date that the employer had notice or knowledge of the work-related injury or illness.

43. Date of Incapacity: **(Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN56 – INITIAL DATE DISABILITY BEGAN)**

    Enter the first day qualifying as a day of incapacity/disability in the first period of incapacity/disability.

    Date Employer Notified: **(Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)**

    Enter the date that the employer had notice or knowledge of the work-related incapacity/disability in the first period of incapacity/disability.

    In the case of sporadic incapacity, enter the date that the employer had notice or knowledge of a day or more collectively lost from work.

44. Time Employee Began Work: **(Not on the IAIABC format)**

    Enter the time the injured employee's workday began on the day of the injury.

45. Date Employer Notified Insurer/TPA: **(Expected) (DN41 – DATE CLAIM ADMINISTRATOR HAD KNOWLEDGE OF THE INJURY)**

    Enter the earlier of the date(s) the claim administrator or the insurer first received notice of the injury or illness from any source.

46. Time of Injury: **(Mandatory) (DN32 – TIME OF INJURY)**

    Enter the time (military format) of the injury.

47. Has Employee Returned to Work? ☐Yes ☐No If box 2a is checked, check either Yes or No. **(Do not check this box if 2a is not checked.)** Check either Yes or No.

    If Yes, Give Date: **(If Available) (DN68 – INITIAL RETURN TO WORK DATE)**

    Where days lost is less than or equal to 7 days, enter the first date on which the employee actually returned to work.

48. Specific Injury or Illness: **(Expected) (DN35 – NATURE OF INJURY CODE)**

    Enter the title corresponding to the Nature of Injury Code.

    Values: see http://www.iaiabc.org/

49. Body Part(s) Affected: **(Expected) (DN36 – PART OF BODY INJURED CODE)**

    Enter the title corresponding to the Part of Body Injured Code.

    Values: see http://www.iaiabc.org/

50. All Equipment, Materials, or Chemicals Employee was Using When the Event Occurred: **(Expected) (DN37 – CAUSE OF INJURY CODE)**

    Enter the title corresponding to the Cause of the Injury Code.

Values: see http://www.iaiabc.org/

51. Specify Activity the Employee was engaged in When the Event Occurred: **(Not on the IAIABC format)**
    Enter a brief description of what the employee was doing at the time of the injury. For example: welding, mowing grass, cooking, typing, moving furniture, etc.
    Was Activity Part of Normal Job Duties? ☐Yes ☐**(Not on the IAIABC format)**
    Check either Yes or No.

52. How Injury or Illness Occurred. Describe the Sequence of Events: **(Expected) (DN38 – ACCIDENT/INJURY DESCRIPTION NARRATIVE**)
    Enter a free form description of how the accident occurred and the resulting injuries.

53. Hospitalized Overnight as Inpatient? ☐Yes ☐No **(Not on the IAIABC format)**
    Check either Yes or No.

54. Was the Employee Treated in an Emergency Room? ☐Yes ☐No **(Not on the IAIABC format)**
    Check either Yes or No.

55. Health Care Provider Name: **(Not on the IAIABC format)**
    Enter the name of the health care provider, if any, who provided initial medical treatment.

56. Mailing Address: **(Not on the IAIABC format)**
    Enter the address of the health care provided reported in Box 55, if applicable.

57. Telephone Number: **(Not on the IAIABC format)**
    Enter the telephone number, including area code, of the health care provider reported in Box 55, if applicable.

58. Preparer Name and Title: **(Not on the IAIABC format)**
    Enter the preparer's name and title.

59. Telephone Number: **(Not on the IAIABC format)**
    Enter the telephone number, including area code, of the preparer reported in Box 58.

60. Date Sent to WCB: **(Mandatory) (DN100 – DATE TRANSMISSION SENT)**
    Enter the actual date the batch of data was sent via EDI to the Board.

NOTES

WAGE STATEMENT

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS): XXX -XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S):_____ NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))	YES ☐ NO ☐

20. LIST GROSS EARNINGS FOR EACH WEEK:

WK 1	WEEK ENDING	GROSS EARNINGS	WK 19	WEEK ENDING	GROSS EARNINGS	WK 37	WEEK ENDING	GROSS EARNINGS
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			**WK OF INJURY**		
17			35			**21. TOTAL EARNINGS $**		
18			36			**22. GROSS AVERAGE WEEKLY WAGE $**		

23. COMMENTS:

24. PREPARER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	25. TELEPHONE NUMBER: ( ) TOLL-FREE NUMBER: ( )	26. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-2 (eff. 1/1/13)

WAGE STATEMENT, WCB-2

Reporting Requirements

The employer/insurer must file a Wage Statement within 30 days after the employer receives notice or has knowledge of a claim for compensation (box 22 of the Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9). See Section 303.

Distribution

A Wage Statement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation of Section 360(1). Violations will result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Board Rule 15.9.

INSTRUCTIONS FOR COMPLETING WAGE STATEMENT, WCB-2

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer’s financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

18. Does Employee Work Concurrently for Another Employer?
    Check Yes or No. If Yes, give name(s) of the concurrent employer(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 concurrent employer(s). See Section 205(8).**

19. Does Employee Receive Fringe Benefits that may stop while on Workers' Compensation?
    Check Yes or No. **NOTE: The employer shall recalculate the average weekly wage if/when fringe benefits cease. Per Section 102(4)(H), "Any fringe or other benefit paid by the employer that does not continue during the disability must be included for purposes of determining an employee's average weekly wage to the extent that the inclusion of the fringe or other benefit will not result in a weekly benefit amount that is greater than 2/3 of the state average weekly wage at the time of injury." The limitation does not apply if the injury results in the employee's death.**

Wage Information

20. Weekly Wages
    If the injured employee was employed seasonally (as defined by Section 102(4)(C)) at the time of injury, enter the employer's payroll week ending dates and the employee's corresponding gross earnings for the prior calendar year.

    For all other types of employment, enter the employer's payroll week ending dates and the employee's corresponding gross earnings for the prior year. Week 52 is the payroll week that includes the date of injury. Week 1 is the payroll week from approximately one year prior to the injury.

    A legible copy of the employer's record of payments (in support of the information reported in box 20) should be attached to the Wage Statement whenever possible.

    Refer to Section 102(4) to determine additional filing requirements.

21. Total Earnings
    Enter the total of gross earnings reported for weeks 1 through 52.

22. Gross Average Weekly Wage

Enter the average weekly wage in accordance with Section 102(4). See Appendix E for sample AWW calculations.

23. Comments
Use this space to provide any comments regarding the AWW calculation.

Preparer Information

24. Preparer Name (Type or Print):
Enter the preparer's name.

E-Mail Address:
Enter the preparer's email address.

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

Toll Free Number:
Enter the preparer's toll free telephone number if one is available.

26. Date Sent to WCB: ___/___/____
MM DD YYYY

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

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 XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

EMPLOYEE COMPLETES BOXES 18 TO 22

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

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY MAINE RELAY 711.

WCB-2A (eff. 1/1/13)

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

Reporting Requirements

For dates of injury prior to 1/1/13, the employer or insurer (which can sometimes be one and the same) must file a Schedule of Dependent(s) and Filing Status Statement within 30 days after the employer's notice or knowledge of a claim for compensation (box 22 of the first Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9).

Distribution

The Schedule of Dependent(s) and Filing Status Statement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

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

Employer/Insurer Completes Boxes 1 To 17

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer’s financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Employee Completes Boxes 18 To 21

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)
    The employee lists 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. Preparer Name and Title:
    The employee signs here.

21. Telephone Number:
    The employee enters a telephone number where he/she can be reached.

22. Date Mailed:
    The employee enters the date he/she completed the form.

NOTE: If the employee fails to (timely) complete boxes 18 through 21, then the employer/insurer can complete these boxes, based on any known filing status and dependent information. If the filing status and dependent information is unknown, we recommend a filing of "single with no dependents". The employer/insurer must document that the employee was contacted and failed to (timely) complete this section.

Upon receipt of the employee's version of the form, a copy should be forwarded to the Board along with any corresponding corrections (if applicable). The newly established weekly compensation rate is effective from the employee's date of injury.

NOTES

FRINGE BENEFITS WORKSHEET

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-			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. EMPLOYEE ADDRESS-NUMBER AND STREET:				
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:	
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:			

PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).

NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.

18. **Fringe Benefit**	**Provided**	**Continues while Employee is out of work**	**Date Benefits End**	**Weekly Cost of Benefits to Employer**
Health Benefits (incl. insurance)	Yes ☐ No ☐	Yes ☐ No ☐		$
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Disability Insurance (incl. short and long term)	Yes ☐ No ☐	Yes ☐ No ☐		$
401K	Yes ☐ No ☐	Yes ☐ No ☐		$
Life Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Education/Training	Yes ☐ No ☐	Yes ☐ No ☐		$
Pension	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$

19. PREPARER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	20. TELEPHONE NUMBER: ( ) TOLL-FREE NUMBER: ( )	21. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.
WCB-2B (eff. 1/1/13)

FRINGE BENEFITS WORKSHEET, WCB-2B

Reporting Requirements

The employer/insurer must file a Fringe Benefits Worksheet within 30 days after the employer's notice or knowledge of a claim for compensation (box 22 of the first Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9). See Section 303.

Other Requirements

The employer shall recalculate the employee's average weekly wage when fringe benefits cease being paid by the employer. The employer must notify the insurer and the employee within seven (7) days when fringe benefits cease by filing an amended wage form, form WCB-2. The insurer or self-insured employer shall file the amended WCB-2 with the Board if it results in increased compensation to the employee. See Rule 1.5.2.B.

Distribution

The Fringe Benefits Worksheet is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING FRINGE BENEFITS WORKSHEET, WCB-2B

Employer/Insurer Completes Boxes 1 To 17

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer’s financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Fringe Benefit Information

18. Fringe Benefits
    Provide the cost of the fringe benefit paid by the employer as of the employee's date of injury if the employee was receiving the benefit on his/her date of injury (see Rule 1.5.1). **NOTE: the amounts reported are subject to verification by the employee and his/her representative and documentation must be provided upon request.**

Preparer Information

19. Preparer Name (Type or Print):
    Enter the preparer's name.

    E-Mail Address:
    Enter the preparer's email address.

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

    Toll Free Number:
    Enter the preparer's toll free telephone number if one is available.

21. Date Sent to WCB: ___/___/____
    MM DD YYYY

    Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**MEMORANDUM OF PAYMENT**	2. WCB FILE NUMBER (if known):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER: ( )
12. DATE OF INJURY: _____/_____/_____ MM DD YYYY	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PARTS (S) AFFECTED:	

EMPLOYER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
18. INSURER NAME:	19.INSURER MAILING ADDRESS AND PHONE NUMBER:	

NOTICE TO EMPLOYEE

20. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS WORKERS' COMPENSATION FORM UPON PAYMENT OF A LOST TIME WORK-RELATED INJURY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

A. ☐ YOUR CLAIM IS ACCEPTED.
B. ☐ THIS IS A VOLUNTARY PAYMENT PENDING INVESTIGATION.
C. ☐ THIS IS A MANDATORY PAYMENT PURSUANT TO RULE 1.1. AMOUNT PAID $ _____. PERIOD COVERED BY MANDATORY PAYMENT:

FROM (DATE CLAIM MADE) _____/_____/_____ MM DD YYYY THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) _____/_____/_____ MM DD YYYY

21. TYPE OF PAYMENT: A. ☐ WEEKLY COMPENSATION B. ☐ SPECIFIC LOSS: _____ WEEKS C. ☐ OTHER (EXPLAIN): _____	22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET: _____/_____/_____ MM DD YYYY

23. DATE OF INCAPACITY: _____/_____/_____ MM DD YYYY DATE EMPLOYER NOTIFIED OF INCAPACITY: _____/_____/_____ MM DD YYYY	24. DATE CHECK MAILED: _____/_____/_____ MM DD YYYY	25. AVERAGE WEEKLY WAGE: $	26. CURRENT WEEKLY COMPENSATION RATE: ☐ TOTAL ☐ PARTIAL $ (IF VARYING RATES ARE BEING PAID, ENTER THE WORD "VARYING")

27. IS THIS AN APPORTIONMENT CLAIM? ☐ YES ☐ NO IF YES, ANSWER THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: _____

OTHER INSURER(S) INVOLVED:

EXPLAIN THE TERMS OF THE APPORTIONMENT: _____

_____

28. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	**BANGOR**	**CARIBOU**	**LEWISTON**	**PORTLAND**
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

29. PREPARER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	30. TELEPHONE NUMBER: ( ) TOLL-FREE NUMBER: ( )	31. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-3 (eff. 1/1/13)

MEMORANDUM OF PAYMENT, WCB-3

Reporting Requirements

The employer/insurer must file a Memorandum of Payment (MOP) with the Board: (1) upon making the first payment of weekly compensation for incapacity due to occupational injury, disease, or death, (2) upon making payment to the Treasurer of Maine in case of the death of any employee when there is no person entitled to compensation, (3) upon making the first payment of weekly compensation for specific loss benefits, (4) upon making a payment of compensation for permanent impairment (pre 1993 claims only), (5) upon making a payment of compensation pursuant to a decision of the Board, (6) upon making a payment of compensation pursuant to Rule 1.1, or (7) once indemnity benefits would otherwise be payable after the seven-day wait period is met for cases involving salary continuation.

A MOP must be sent to the Board on or before the 14th day payment is due under Section 205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where the form is sent via standard mail). Evidence of timely mailing is a rebuttable presumption to a determination of noncompliance under Section 360(1).

Other Requirements

Compliance with the initial indemnity payment obligation exists when the check is mailed within the later of: 1) 14 days after the employer's notice or knowledge of incapacity or 2) the first day of compensability plus 6 days. If an employer continues to pay the employee's salary, payments are deemed timely for purposes of compliance if made consistent with the employer's usual payroll practice.

The employer/insurer must file a Wage Statement and a Fringe Benefits Worksheet within 30 days after the employer's notice or knowledge of a claim for compensation (box 22 of the first Memorandum of Payment, WCB-3). See Section 303.

Distribution

A MOP is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 Employee
Copy 3 Insurer
Copy 4 Employer

Closure

Closure of all MOPs other than those issued pursuant to Rule 1.1 is required. Closure occurs when one of the following actions is taken:

1) File a Discontinuance or Modification of Compensation, WCB-4, when:

    a. The employee has returned to work for the employer of injury and/or the employee's post-injury wages (from the employer of injury) equal or exceed his/her pre-injury AWW

    b. The employee has returned to work for the employer of injury without restrictions or limitations (due to the injury for which benefits are being paid), according to the employee's treating health care providers and there are no conflicting medical records with respect to the lack of restrictions or limitations (due to the injury for which benefits are being paid)

    c. Board decision (e.g. a mediation agreement, Consent Decree, Hearing Officer Decree, or Lump Sum Settlement)

2) File a Certificate of Discontinuance or Reduction of Compensation, WCB-8, when:

    a. Indemnity benefits are suspended in accordance with Section 205(9)(B)(1)

3) File a Petition when:

    a. Indemnity benefits are suspended in accordance with Section 205(9)(B)(2)

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

Other Violations

Failure to file a Notice of Controversy (denial) or pay benefits on or before the 14th day payment is due under Section 205(2) is a violation of Rule 1.1. This violation requires payment of benefits to the injured employee as set forth in Rule 1.1, which must be reported on a MOP, as required by Rule 1.1.

Failure to file a denial or pay benefits on or before 30 days after the 14th day payment is due under Section 205(2) requires a penalty payment to the injured employee, as set forth in Section 205(3).

INSTRUCTIONS FOR COMPLETING MEMORANDUM OF PAYMENT, WCB-3

1. Revision Date: ___/___/____
   MM DD YYYY

   If you are amending any information on this form that has already been filed with the parties involved (Board, employee, insurer, employer), enter the date (month, day, year) that this amended form is sent to the parties.

2. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employee

3. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. M.I.:
   Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. Street/P.O. Box Mailing Address:
   Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

8. City:
   Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. State:
   Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. Date of Injury: ___/___/____
    MM DD YYYY

    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. Specific Injury or Illness:
    Enter the specific injury or illness as it was entered in box 48 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Body Part(s) Affected:
    Enter body part(s) affected as it was entered in box 49 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Employer

15. Insurer File Number:
    Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Employer Name:
    Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Employer Mailing Address and Phone Number:
    Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

18. Insurer/TPA Name:
    Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

19. Insurer/TPA Mailing Address:
    Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Notice to Employee

20. Your Employer/Insurer is required to file this Workers' Compensation form upon payment of a lost time work-related injury. Payment is made for the following reason:

A. ☐ Your Claim is Accepted (payment with prejudice).
Check box A if the employer/insurer is accepting the claim.

B. ☐ This is a Voluntary Payment Pending Investigation (payment w/out prejudice).
Check box B if the employer/insurer plans to investigate the claim.

C. ☐ This is a Mandatory Payment Pursuant to Rule 1.1. Amount Paid $_____

Period Covered by Mandatory Payment: From (Date Claim Made __/___/____
MM DD YYYY

Through (Date NOC filed/benefits paid)___/___/____
MM DD YYYY

Check box C if payment is required pursuant to Rule 1.1. If the employer fails to comply with the provisions of Rule 1.1, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met:

i. The employer files a Notice of Controversy; and

ii. The employer pays benefits from the date the claim is made. If it is later determined that the average weekly wage/compensation rate used to compute the payment due was incorrect, and the amount paid was reasonable and based on the information gathered at the time, the violation of Rule 1.1 is deemed to be cured.

21. Type of Payment:

A. ☐ Weekly Compensation (§212(1), 213(1) or former §54, 54-A, 54-B, 55, 55-A, 55-B)

B. ☐ Specific Loss _____Weeks (§212(3))

C. ☐ Other (Explain) _____

Check the box that describes the reason for the payment.

If Specific Loss is checked, enter the number of weeks payable.

If Other is checked, enter a brief description of the type of payment, e.g. Permanent Impairment (pre 1993), Salary Continuation, decision, occupational deafness (§612), death of any employee when there is no person entitled to compensation (§355(14)(F)), etc.

22. First Day of Compensability After Waiting Period is Met:___/___/____
MM DD YYYY

Complete this box if (1) the current incapacity is subject to the seven-day waiting period provided by Section 204, or (2) this is the initial MOP for a firefighter claim. Otherwise, do not complete this box.

For non-firefighter claims, enter the first day of incapacity after the seven-day wait has been met. For firefighter claims, enter the date of incapacity reported in box 23.
In the case of total incapacity, the seven-day waiting period is met when the employee is incapacitated for seven calendar days (regardless of salary continuation – see below).

In the case of partial incapacity, the seven-day waiting period is met when (1) an employee loses wages because of the injury which cumulatively equal or exceed the employee's pre-injury AWW, or (2) an employee loses wages because of the injury that would otherwise require the insurer to pay one week of benefits.

For cases involving salary continuation, this calculation should be made as if the employee has lost the wage that is being continued during the time he or she is absent from work or when the employee misses time from work that equals the hours worked in a regular work week. See Appendix D for more information.

23. Date of Incapacity: ___/___/____
MM DD YYYY

Initial MOP: Enter the initial date disability began in the initial period of disability as it was entered in box 43 of the Employer's First Report of Occupational Injury or Disease, WCB-1. (Occupational disease claims: enter the date of injury reported in box 12.)

Subsequent MOP: Enter the first qualifying day of disability in the current period of disability being paid.

Specific loss claims (initial or subsequent MOP): Enter the date of the specific loss.

Date Employer Notified of Incapacity: ___/___/____
MM DD YYYY

Initial MOP: Enter the date that the employer had notice or knowledge of the work-related incapacity/disability in the first period of incapacity/disability as it was entered in box 43 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Subsequent MOP: Enter the date that the employer had notice or knowledge of the first qualifying day of disability in the current period of disability being paid.

Specific loss claims (initial or subsequent MOP): Enter the date that the employer had notice or knowledge of the specific loss.

24. Date Check Mailed: ___/___/_____
MM DD YYYY

Enter the date payment was first mailed to the employee for the current incapacity. For cases involving salary continuation, enter the date the payroll check is mailed or delivered or the salary is deposited.

25. Average Weekly Wage:
Enter the employee's average weekly wage pursuant to Section 102(4). If estimated, please indicate.

26. Current Weekly Compensation Rate:
☐ Total ☐ Partial $
Check the appropriate box to indicate whether payment is for total or partial incapacity. Also, enter the dollar amount of the current compensation rate or applicable maximum. (Rates are based on the law in effect at the time of the injury.) Enter "Varying" in place of the dollar amount for varying rates. For cases involving salary continuation, enter the compensation rate that would otherwise be paid or the applicable maximum.

27. Is This an Apportionment Claim?
If this claim has been apportioned with another work-related injury, check Yes; otherwise, check No. If Yes is checked, answer all questions asked about the apportionment:

Other Date(s) of Injury Involved:
Other Insurer(s) Involved:
Explain the Terms of the Apportionment:

28. Comments
Use this area to enter any additional information, explanations or clarifications.

For cases involving permanent impairment (pre 1993 claims only), include the permanent impairment rating, number of weeks, and the amount of permanent impairment benefits paid.

For cases involving salary continuation, enter the salary amount that is being paid and any additional partial workers' compensation benefits due under Section 213, as applicable.

Preparer Information

29. Preparer Name (Type or Print):
Enter the preparer's name.

E-Mail Address:
Enter the preparer's email address.

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

Toll Free Number:
Enter the preparer's toll free telephone number if one is available.

31. Date Sent to WCB: ___/___/____
MM DD YYYY

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Workers' Compensation Board. If the form being sent is a revision of a previous form, maintain the original Date Sent to WCB date and enter the revision date in box 1.

NOTES

DISCONTINUANCE OR MODIFICATION OF COMPENSATION PURSUANT TO 39-A M.R.S.A. §205(9)(A)

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

PLEASE COMPLETE EITHER THE SECTION FOR DISCONTINUANCE OR MODIFICATION, BUT NOT BOTH.

DISCONTINUANCE

18. REASON FOR DISCONTINUANCE:

☐ RETURNED TO WORK FOR SAME EMPLOYER REGULAR/FULL DUTY MEDICAL RELEASE
☐ RETURNED TO WORK FOR SAME EMPLOYER EARNING AT/ABOVE AVERAGE WEEKLY WAGE
☐ BOARD DECISION
☐ OTHER (EXPLAIN) _____

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

23. COMMENTS:

MODIFICATION

24. REASON FOR MODIFICATION:

☐ RETURNED TO WORK FOR SAME EMPLOYER MODIFIED WORK/DUTY
☐ COST OF LIVING ADJUSTMENT (PRE 1993 CLAIMS ONLY)
☐ INCREASED/DECREASED EARNINGS WITH SAME EMPLOYER
☐ BOARD DECISION
☐ MAX RATE INCREASE
☐ OTHER (EXPLAIN) _____

25. OLD COMPENSATION RATE:	26. NEW COMPENSATION RATE:	27. EFFECTIVE DATE OF MODIFICATION:

28. COMMENTS:

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

29. PREPARER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	30. TELEPHONE NUMBER: ( ) TOLL-FREE NUMBER: ( )	31. DATE MAILED: ____/____/____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-4 (eff. 1/1/13)

DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

Reporting Requirements

The employer/insurer files this form for such reasons as the discontinuance or modification of compensation pursuant to Section 205(9)(A) or 205(9)(B)(2), a Board decision, a mediation agreement, cost-of-living adjustments, Social Security offsets, and unemployment compensation offsets. **NOTE: This form is not used for discontinuances or reductions under Section 205(9)(B)(1).**

Returned to Work for Same Employer: Reductions and discontinuances pursuant to Section 205(9)(A) must be based on the employee's actual earnings, however, an employer/insurer may discontinue benefits regardless of the employee's actual earnings if: (i) the employee returns to work without restrictions or limitations, due to the injury for which benefits are being paid, according to the employee's treating health care providers; and (ii) there are no conflicting medical records with respect to the lack of restrictions or limitations due to the injury for which benefits are being paid. The Discontinuance or Modification of Compensation must be filed within 14 days after the employee returns to work or receives an increase in pay. See Rule 8.11.

Board Decision: When the employee's benefits are discontinued or modified in accordance with a decree, a Discontinuance or Modification of Compensation must be filed. See Rule 8.12.

Mediation Agreement: When the employee's benefits are discontinued or modified in accordance with a Mediation Agreement, a Discontinuance or Modification of Compensation must be filed within 14 days from the date of the agreement. See Rule 8.12.

Petition for Review: When the employee's benefits are discontinued or modified based on the amount of actual documented earnings paid to the employee after filing the petition, the employer/insurer shall file the actual documented earnings and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review. Thereafter, the employer/insurer shall, within 30 days after receipt of the actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4. See Rule 8.15.3.

Other: When the employee's benefits are discontinued, reduced or modified for any other reason (cost-of-living adjustment, Social Security offset, unemployment offset, etc.), a Discontinuance or Modification of Compensation must be filed.

Distribution

A Discontinuance or Modification of Compensation is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation of Section 360(1). Violations will result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Rule 15.9.

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

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

Discontinuance

18. Reason for Discontinuance:
- ☐ Returned to Work for Same Employer (Regular/Full Duty Medical Release)
- ☐ Board Decision
- ☐ Returned to Work for Same Employer (Earning At/Above AWW)
- ☐ Other (Explain) _____

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 this incapacity began. This date should be the same as box 23 (date of incapacity) of the Memorandum of Payment, WCB-3, for the current incapacity period.

To (Return Date): Enter the date this incapacity ended. **NOTE: Enter only one period of incapacity in box 19 per form.**

20. Weekly Compensation Rate:
Enter the weekly compensation rate used for this period of incapacity. If varying rates were paid, enter the word "Varying". If more than one rate was used, enter the last rate used.

21. Amount Paid:
Enter the total amount of weekly compensation paid for the period of incapacity reported in box 19. **Do not reduce this total by the amount of any recoveries. For cases involving apportionment, do not include amounts paid to the "lead" carrier. For cases involving salary continuation, do not include amounts paid by the employer.**

22. Date Final Payment Mailed:
Enter the date the last weekly compensation payment for this period of incapacity was mailed to the employee.

23. Comments:
Use this space to provide any comments.

Modification

24. Reason for Modification:
- ☐ Returned to Work for Same Employer (Modified Work/Duty)
- ☐ Board Decision
- ☐ Cost of Living Adjustment (Pre 1993 claims only)
- ☐ Max Rate Increase

☐ Increased/Decreased Earnings with Same Employer
☐ Other (Explain) _____

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

25. Old Compensation Rate:
Enter the compensation rate prior to the change. If varying rates were paid, enter the word "Varying".

26. New Compensation Rate:
Enter the new compensation rate. If varying rates will be paid, enter the word "Varying".

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

28. Comments:
Use this space to provide any comments.

Preparer Information

29. Preparer Name (Type or Print):
Enter the preparer's name.

E-Mail Address:
Enter the preparer's email address.

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

Toll Free Number:
Enter the preparer's toll free telephone number if one is available.

31. Date Sent to WCB: ___/___/____
MM DD YYYY

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

CONSENT BETWEEN EMPLOYER AND EMPLOYEE

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER XXX-XX-			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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. TERMS OF CONSENT:			
18A. DATE OF INCAPACITY:	18B. AVERAGE WEEKLY WAGE:	18C. CURRENT WEEKLY COMPENSATION RATE: ☐ TOTAL ☐ PARTIAL	18D. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): ☐ YES ☐ NO
18E. NEW COMPENSATION RATE:	18F. EFFECTIVE DATE OF REDUCTION:	18G. EFFECTIVE DATE OF DISCONTINUANCE:	18H. AMOUNT PAID:

NOTICE TO EMPLOYEE (Please read and initial)

19.
BEFORE YOU SIGN THIS FORM, YOU SHALL CALL THE WORKERS' COMPENSATION BOARD'S OFFICES TO FIND OUT WHAT RIGHTS YOU HAVE IF YOU SIGN THIS FORM. A LIST OF THE BOARD'S REGIONAL OFFICES IS SHOWN AT THE BOTTOM OF THIS PAGE.

EMPLOYEE INITIALS: _____

NOTICE TO EMPLOYER

THIS FORM SHALL NOT BE USED FOR CASES WHEN AN ORDER, AWARD OF COMPENSATION OR A COMPENSATION SCHEME WAS ENTERED UNDER SECTION 205 (9)(B)(2).

CONSENT

20.
WE AGREE TO THE TERMS LISTED IN BOX 18 ABOVE. WE UNDERSTAND THAT THIS IS NOT A FINAL SETTLEMENT. SIGNING THIS CONSENT FORM CREATES A PAYMENT WITHOUT PREJUDICE, DOES NOT CREATE A PAYMENT SCHEME, AND DOES NOT PREVENT EITHER PARTY FROM REOPENING THE CLAIM WITHIN CERTAIN TIME LIMITS. THIS FORM MUST BE SIGNED BY THE EMPLOYEE, EMPLOYEE'S ATTORNEY OR WORKER ADVOCATE IF ANY, AND THE EMPLOYER/INSURER OR BY A DULY AUTHORIZED REPRESENTATIVE.

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____
EMPLOYEE 'S AUTHORIZED REPRESENTATIVE SIGNATURE (IF APPLICABLE) DATE

_____ _____
EMPLOYER/INSURER OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

21. PREPARER NAME AND TITLE (TYPE OR PRINT):	22. TELEPHONE NUMBER:	23. DATE MAILED:

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-4A (eff. 1/1/13)

CONSENT BETWEEN EMPLOYER AND EMPLOYEE, WCB-4A

Reporting Requirements

Pursuant to Rule 8.18, the Consent Between Employer and Employee (WCB-4A) may be used when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification, reduction or discontinuance in ongoing weekly incapacity benefits.

- The Consent Between Employer and Employee (WCB-4A) can not be used to reduce or discontinue benefits on a date that is subsequent to the date the parties sign the WCB-4A.

- The WCB-4A shall be signed by the employee, the employee's attorney or worker advocate, if any, and a representative of the employer/insurer.

- The parties may agree to the pre-injury average weekly wage or may agree to pay benefits based upon a provisional wage and reserve the issue of the pre-injury average weekly wage for later determination by the Board. In either event, the form shall also indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the form shall indicate the percentage of benefits that the employee is receiving.

- The employer or insurance carrier shall make compensation payments within 10 calendar days after the WCB-4A is signed by the parties.

- Signing the WCB-4A does not by itself create a compensation payment scheme.

- Upon request by any of the parties, the Consent Between Employer and Employee, WCB-4A, shall be reviewed within 14 calendar days by an agent at the Board's regional offices in order to answer any relevant questions prior to the employer and employee signing this form.

- The Consent Between Employer and Employee, WCB-4A, shall not be used when an ongoing order, award of compensation, or a compensation payment scheme is entered under Section 205(9)(B)(2).

Distribution

A Consent Between Employer and Employee is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee
Copy 3 to the Insurer
Copy 4 to the Employer

Form Filing Violations

The Deputy Director of Benefits Administration will refer abuses of the Consent Between Employer and Employee, WCB-4A, to the Workers' Compensation Abuse Investigation Unit.

Other Violations

The Payments Division will review the Consent Between Employer and Employee, WCB-4A, in order to verify that the agreed upon benefits were correctly determined.

INSTRUCTIONS FOR COMPLETING CONSENT BETWEEN EMPLOYER AND EMPLOYEE, WCB-4A

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name
   Enter the employee's last name as entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury
    Enter a brief description of the injury or illness.

Terms of Consent

18. Terms of Consent

Enter the details/terms of the agreement between the parties. The terms shall indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the terms shall indicate the percentage of benefits that the employee is receiving.

18A. Date of Incapacity

Enter the date of the first day that will be compensated when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or the date of incapacity as entered in box 23 of the Memorandum of Payment, WCB-3 when the parties have agreed to a voluntary modification, reduction or discontinuance of compensation.

18B. Average Weekly Wage

Enter the average weekly wage as entered in box 25 of the Memorandum of Payment, WCB-3, or the average weekly wage as agreed upon by the parties, if applicable.

18C. Current Weekly Compensation Rate: ☐ Total ☐ Partial $_____

Check the appropriate box to indicate whether payment is for total or partial incapacity and enter the weekly compensation rate agreed upon by the parties when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or the current weekly compensation rate when the parties have agreed to a voluntary modification, reduction or discontinuance of compensation.

18D. Does Employee Work For Another Employer?

If the employee was employed by more than one employer at the time of the injury, check Yes; otherwise, check no.

If Yes, Give Name(s)

If the employee was employed by more than one employer at the time of the injury, enter the name of the other employer(s).

18E. New Compensation Rate

Use this box only when the parties have agreed to a voluntary modification or reduction in compensation. Enter the new compensation rate agreed upon by the parties. If varying rates will be paid, enter the word "Varying".

18F. Effective Date of Reduction

Use this box only when the parties have agreed to a voluntary modification or reduction in compensation. Enter the effective date of the modification or reduction, as agreed upon by the parties.

18G. Effective Date of Discontinuance

Use this box only when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or a voluntary discontinuance of compensation. Enter the effective date of the discontinuance, as agreed upon by the parties.

18H. Amount Paid

Use this box only when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or when the parties have agreed to a voluntary discontinuance of compensation. Enter the total amount of indemnity to be paid for the retroactive closed-end period of incapacity or for the period of incapacity being paid or discontinued by the agreement of the parties. **NOTE: Do not reduce this total by the amount of any recoveries. For cases involving apportionment, do not include amounts paid to the "lead" carrier. For cases involving salary continuation, do not include amounts paid by the employer.**

Notice To Employee

19. This box should be initialed by the employee to ensure that he/she has read the notice.

Consent

20. This area shall be signed by the employee, the employee's attorney or worker advocate, if any, and a representative of the employer/insurer before it may be accepted by the Board.

Preparer Information

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

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

23. Date Mailed:
Enter the date this form is sent this form is sent (mail, fax, email) to the Board.

NOTES

CERTIFICATE AUTHORIZING
RELEASE OF BENEFIT INFORMATION

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

PART I (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

PART II (COMPLETED BY EMPLOYEE)

I, _____, AUTHORIZE THE EMPLOYER/INSURER TO OBTAIN WRITTEN INFORMATION INDICATING THE NATURE AND AMOUNT OF BENEFITS I RECEIVED OR AM RECEIVING FROM THE FOLLOWING:

☐ SOCIAL SECURITY ADMINISTRATION

☐ EMPLOYEE BENEFITS PLAN

_____
NAME OF EMPLOYEE BENEFIT PLAN

_____
ADDRESS- NUMBER AND STREET

_____
CITY, STATE, ZIP

I UNDERSTAND THAT THE EMPLOYER/INSURER IS ENTITLED TO RECEIVE THIS SOCIAL SECURITY OLD AGE INSURANCE OR EMPLOYEE BENEFIT PLAN INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5) AND THAT **MY FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT MY WORKERS' COMPENSATION INDEMNITY BENEFITS.** THIS CERTIFICATE OF RELEASE IS VALID FOR ONE YEAR FROM THE DATE OF MY SIGNATURE.

SIGNATURE: _____ DATE:_____

PART III (COMPLETED BY SOCIAL SECURITY ADMINISTRATION OR EMPLOYEE BENEFIT PLAN ADMINISTRATOR)

THE EMPLOYEE AUTHORIZES THE RELEASE OF BENEFIT INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5). PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE EMPLOYER/INSUER:

1. EFFECTIVE DATE OF ELIGIBILITY: _____
2. CURRENT GROSS MONTHLY AMOUNT: _____
3. PERCENTAGE OF EMPLOYEE BENEFIT PLAN PAID BY EMPLOYER (IF APPLICABLE): _____
4. IF BENEFITS FROM THIS EMPLOYEE BENEFIT PLAN ARE SUBJECT TO REDUCTION BASED ON RECEIPT OF WORKERS' COMPENSATION BENEFITS, PLEASE EXPLAIN:

5. COMMENTS:

6. BENEFIT INFORMATION SENT TO THE EMPOYER/INSURER ON: _____

SIGNATURE: _____ DATE:_____

PREPARER NAME (TYPE OR PRINT):_____ TELEPHONE NUMBER:_____

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-6 (eff. 1/1/13)

CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION, WCB-6

Reporting Requirements

The employer/insurer may use the Certificate Authorizing Release of Benefit Information to request information about payments made to an injured employee for one of the following:

- Old-age insurance under the United States Social Security Act, 42 United States Code, Sections 301 to 1397f.
- An employer-funded self-insurance plan.
- An employer-funded wage continuation plan.
- An employer-funded disability insurance policy.
- An employer established or maintained pension plan or program.
- An employer established or maintained retirement plan or program.

The employer/insurer must complete Part I and have the injured employee complete Part II (release of information) before submitting the form to the Social Security Administration or other party who provides one of the above-listed employee benefit plans for completion of Part III.

INSTRUCTIONS FOR COMPLETING CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION, WCB-6

Part I Employer/Insurer Completes Boxes 1 Through 17

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer’s financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

Part II Employee Completes This Section

Part III Social Security Administration or Employee Benefit Plan Completes This Section

NOTES

CERTIFICATE AUTHORIZING
RELEASE OF UNEMPLOYMENT INFORMATION

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

PART I (COMPLETED BY REQUESTOR)				
1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

PART II (COMPLETED BY EMPLOYEE)

I, _____, understand that the information in my unemployment compensation file(s) is confidential under 26 M.R.S.A. §1082(7), of the Maine Revised Statutes. However, I waive my right to confidentiality and authorize the Workers' Compensation Board to obtain and release that information, pertaining to the benefit year ending ____/____/____, or calendar period from _____ through _____ to the following:

Name: _____

Title: _____

Address: _____

_____

I understand that I may also request a copy of this information be sent to me. A copy of this waiver/consent is acceptable.

Signature:_____ Date:_____

PART III (COMPLETED BY THE WORKERS' COMPENSATION BOARD)

Unemployment information sent to the requestor on _____.

Signature:_____ Date:_____

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-7 (eff. 01/1/13)

CERTIFICATE AUTHORIZING RELEASE OF UNEMPLOYMENT INFORMATION, WCB-7

Reporting Requirements

The Certificate Authorizing Release of Unemployment Information may be used to request information about unemployment benefits made to an injured employee.

The requesting party must complete Part I and have the injured employee complete Part II (release of information) before submitting the form to the Workers' Compensation Board.

INSTRUCTIONS FOR COMPLETING CERTIFICATE AUTHORIZING RELEASE OF UNEMPLOYMENT INFORMATION, WCB-7

Part I Requestor Completes Boxes 1 Through 17

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Part II Employee Completes This Section

Part III For Board Use Only

NOTES

CERTIFICATE OF
DISCONTINUANCE OR REDUCTION OF COMPENSATION
PURSUANT TO 39-A M.R.S.A. §205(9)(B)(1)

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
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 MAY FILE A PETITION FOR REVIEW AND REQUEST REINSTATEMENT OF YOUR BENEFITS PENDING HEARING, UNDER 39-A M.R.S.A. §205(9)(C). YOUR PETITION AND REQUEST (ON FORM WCB-121) MUST BE MAILED TO THE WORKERS' COMPENSATION BOARD ADDRESS ABOVE.

18. REASON FOR DISCONTINUANCE OR REDUCTION (MUST ATTACH SUPPORTING DOCUMENTATION):

DISCONTINUANCE

19. PERIOD OF INCAPACITY: FROM (DATE): TO (EFFECTIVE DATE OF DISCONTINUANCE):	20. WEEKLY COMPENSATION RATE:	21. COMPENSATION PAID 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:

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

26. PREPARER NAME (TYPE OR PRINT):	27. TELEPHONE NUMBER:	28. DATE MAILED (MUST MATCH POSTMARK):
E-MAIL ADDRESS:	( ) TOLL-FREE NUMBER: ( )	____/____/____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-8 (eff. 1/1/13)

(21-DAY) CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

Reporting Requirements

The employer/insurer must file a 21-Day Certificate of Discontinuance or Reduction of Compensation when compensation is discontinued or reduced pursuant to Section 205(9)(B)(1).

Reductions and/or discontinuances based on earnings when an employee returns to work with a different employer: When the employee's benefits are discontinued or modified based on the amount of actual documented earnings, the employer/insurer must include, with the 21-Day Certificate of Discontinuance or Reduction of Compensation, form 231-A (Employee's Return to Work Report). Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

A 21-day Certificate of Discontinuance or Reduction of Compensation must be sent **by certified mail** to the Board and to the employee (box 28).

Distribution

A Certificate of Discontinuance or Reduction of Compensation is a four-part form that is to be distributed as follows:

Copy 1 to the Board **via certified mail** at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 to the Employee **via certified mail** no less than 21 days prior to the effective date (box 19 or box 25) of the form.

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:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer’s financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

18. Reason for Discontinuance or Reduction of Benefits:
    Enter the reason for discontinuing or reducing compensation, and attach supporting documentation.

Discontinuance

19. Period of Incapacity:
    From (Date):
    Enter the date this period of incapacity began. This date should be the same as box 23 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 (no earlier than 21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, box 28). 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 28)
+21 (days)
= May 26 (effective date of discontinuance)

20. Weekly Compensation Rate:
Enter the weekly compensation rate used for this period of incapacity. If varying rates were paid, enter the word "Varying". If more than one rate was used, enter the last rate used.

21. Compensation Payment to Date of Certificate:
Enter the total amount of weekly compensation paid to date (date the Certificate of Discontinuance or Reduction of Compensation is mailed) for the current incapacity period. **NOTE: Do not reduce this total by the amount of any recoveries. For cases involving apportionment, do not include amounts paid to the "lead" carrier. For cases involving salary continuation, do not include amounts paid by the employer.**

22. Compensation to be Paid for 21-Day Period:
Enter the total anticipated amount of weekly compensation to be paid for the 21-day notice period.

Reduction

23. Old Compensation Rate:
Enter the compensation rate prior to change. If varying rates were paid, enter the word "Varying".

24. New Compensation Rate:
Enter the new compensation rate. If varying rates will be paid, enter the word "Varying".

25. Effective Date of Reduction:
Enter the date payment for the incapacity will be reduced (no earlier than 21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, box 28). 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 28)
+21 (days)
= May 26 (effective date of reduction)

Preparer Information

26. Preparer Name (Type or Print):
Enter the preparer's name.

E-Mail Address:
Enter the preparer's email address.

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

Toll Free Number:
Enter the preparer's toll free telephone number if one is available.

28. Date Mailed: ___/___/____
MM DD YYYY

Enter the date the Certificate of Discontinuance or Reduction of Compensation was mailed certified to the injured employee and the Board. This date should be 21 days prior to the effective date shown in box 19 (discontinuance) or box 25 (reduction) and match the postmark on the Certified Sender's Receipt.

NOTES

NOTICE OF CONTROVERSY

THIS IS A DENIAL OF YOUR BENEFITS

1. WCB FILE # (if known):

EMPLOYEE

2. EMPLOYEE LAST NAME:	3. FIRST NAME:	4. MI:	5. EMPLOYEE ID: TYPE: #:	
6. STREET/P.O. BOX MAILING ADDRESS:	7. CITY:	8. STATE:	9. ZIP:	10. HOME PHONE #: ( )
11. DATE OF INJURY: _____/_____/_____	12. SPECIFIC INJURY OR ILLNESS:		13. BODY PART(S) AFFECTED:	

EMPLOYER

14. INSURER/CLAIM ADMIN FILE #:	15. EMPLOYER NAME:	16. EMPLOYER MAILING ADDRESS AND PHONE #:
17. INSURER/CLAIM ADMIN NAME AND ADDRESS:		18. INSURER/CLAIM ADMIN FEIN:

19.

NOTICE TO EMPLOYEE

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW.
IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

19a.

FULL DENIAL REASON

19b.

PARTIAL DENIAL REASON

20a.

DATE OF INITIAL INCAPACITY ____/____/____

CURRENT DTE OF INCAPACITY ____/____/____

20b.

DATE EMPLOYER NOTIFIED _____/_____/_____

FULL DENIAL EFFECTIVE DATE _____/_____/_____

*NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.

21. COMMENTS:

22. If the employer fails to comply with the provisions of Rule 1.1, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S. § 205(2) and in compliance with 39-A M.R.S. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met: A. The employer files a Notice of Controversy; and B. The employer pays benefits from the date the claim is made. Payment under Rule 1.1 requires filing of a Memorandum of Payment.

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

23. NAME (TYPE OR PRINT):	24. TELEPHONE #:	25. DATE SENT TO WCB:
E-MAIL ADDRESS:	( )	26. DATE RCVD AT THE WCB (WCB use only):

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WCB-9 (eff. 1/1/13)

NOTICE OF CONTROVERSY (DENIAL), WCB-9

General Reporting Requirements
The employer/insurer must file* a Notice of Controversy (NOC) with the Board to report the denial of a claim for incapacity (disability), death and/or medical benefit(s).

Denial of Incapacity (disability) Benefits: Where the claim for incapacity (disability) benefits is in dispute, a NOC must be filed* on or before the 14th day payment is due under Section 205(2).

Denial of Death Benefits: Where the claim for death benefits is in dispute, a NOC must be filed* on or before the 14th day payment is due under Section 205(2).

Denial of Medical Benefits: Where the employee's claim is only for medical benefits, a NOC shall be filed* on or before the 30th day after notice or knowledge of the claim for medical benefits. See Rule 8.2 for exceptions and further instructions.

Other Reporting Requirements
The employer/insurer must file a Wage Statement and a Fringe Benefits Worksheet within 30 days after the employer's notice or knowledge of a claim for compensation (box 20 of NOC, WCB-9). See Section 303.

EDI Reporting Requirements
Unless a waiver has been granted, effective July 1, 2006, all denials and all MTC CO corrections to denials (that are the result of a TE transaction error) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC). The MTC is a code that identifies the type of transaction:

MTC Code	Definition
CO	Correction: Correct transaction reported on the AKC as TE (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction.
04	Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board.

* accepted EDI transaction, with or without errors (TE or TA only)

04	Full Denial: A SROI 04 transaction indicates a Full Denial on a FROI that has been previously filed with the Board. The jurisdiction claim number/WCBN is mandatory for this transaction.
PD	Partial Denial: A SROI PD transaction indicates a Partial Denial. The jurisdiction claim number/WCBN is mandatory for this transaction.

If the claim is being denied in part, the FROI must be filed* prior to the submission of the Partial Denial. If the claim is being denied in full, the employer/insurer may file* a FROI 04 (the original FROI and Full Denial in one transaction).

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

DN0111	**Definition**
HD	Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the claim administrator's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A denial is not considered filed with the Board until it receives a TA or TE code on the AKC.

Corrections

Changes to NOCs filed prior to July 1, 2006 using a paper WCB-9 (10/98) must be made by sending an amended paper WCB-9 (10/98) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.

* accepted EDI transaction, with or without errors (TE or TA only)

A MTC CO EDI transaction must be sent to the Board to correct any TE errors that were received on an acknowledgement report.

Changes/updates to denials that have been filed electronically (and are not the result of a TE transaction error) must be made by sending a paper WCB-9 (1/12/06) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board
27 State House Station
Augusta, ME 04333-0027

PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.

Distribution

WCB-9 (1/12/06) shall be mailed to the employee, the employer and, if required by Rule 5.7.2 or Rule 8.2, the health care provider, within 24 hours after the denial is transmitted to the Board.

Closure

Closure of the denial is required. Closure occurs when one of the following actions is taken:

1) The employer or carrier withdraws the denial. This requires the filing of a Memorandum of Payment, WCB-3, when indemnity payments are made.
2) Denied benefit(s) are not pursued.
3) The parties reach agreement outside of the litigation process. This requires the filing of a Memorandum of Payment, WCB-3, or a Consent Between Employer and Employee form, WCB-4A, when the agreement includes indemnity payments.
4) The parties reach agreement at Mediation. This requires the filing of a Memorandum of Payment, WCB-3, when the agreement includes indemnity payments.
5) A petition is filed by the denied party after unsuccessful Mediation.

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

Other Violations

Failure to deny or pay benefits on or before the 14th day payment is due under Section 205(2) is a violation of Rule 1.1. This violation requires payment of benefits to the injured employee as set forth in Rule 1.1, which must be reported on a Memorandum of Payment, WCB-3, as required by Rule 1.1. Failure to deny or pay benefits on or before 30 days after the 14th day payment is due under Section 205(2) requires a penalty payment to the injured employee, as set forth in Section 205(3). Failure to deny or pay medical benefits within 30 days after receipt of notice of nonpayment by certified mail requires a penalty payment to the provider of the medical or health care services or the employee who paid for the medical or health care services, as set forth in Section 205(4).

INSTRUCTIONS FOR COMPLETING NOTICE OF CONTROVERSY, WCB-9

For instructional purposes, this Forms Manual indicates the WCB-9 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist claim administrators with electronic filing and paper distribution of denials. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any mandatory fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a TR on the AKC. A TR on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any expected fields are missing, incomplete or incorrect, the denial will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC CO using the jurisdiction claim number/WCBN provided in the acknowledgement report.

1. WCB File # (if known): **(Assigned for FROI 04; Mandatory for SROI CO, SROI 04 and SROI PD) (DN5 – JURISDICTION CLAIM NUMBER)**
   Enter the file number assigned by the Board to identify this claim**.**

2. Employee Last Name:
   (DN43 – EMPLOYEE LAST NAME) (Mandatory)
   (DN255- EMPLOYEE LAST NAME SUFFIX) (If Available)
   Enter the employee's legally recognized last name and last name suffix.

3. First Name: **(Mandatory) (DN44 – EMPLOYEE FIRST NAME)**
   Enter the employee's first name.

4. MI: **(If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)**
   Enter the employee's middle initial.

5. Employee ID: **(Mandatory)**
   Enter the employee's ID type (**DN270 – EMPLOYEE ID TYPE QUALIFIER)**
   Values: A= Employee ID Assigned by Jurisdiction (DN154)
   E= Employee Employment Visa (DN152)
   G=Employee Green Card (DN153)
   P=Employee Passport Number (DN156)
   S=Employee Social Security Number (DN42)

   Enter the employee's ID #: **(Expected)**
   DN042 – EMPLOYEE SSN
   DN152 – EMPLOYEE EMPLOYMENT VISA
   DN153 – EMPLOYEE GREEN CARD
   DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION
   DN156 – EMPLOYEE PASSPORT NUMBER

6. Street/P.O. Box Mailing Address: **(Expected on FROI 04) (DN46 – EMPLOYEE MAILING PRIMARY ADDRESS)**
   Enter the employee's mailing address.

7. City: **(Expected on FROI 04) (DN48 – EMPLOYEE MAILING CITY)**
   Enter the city of the employee's mailing address.

8. State: **(Expected on FROI 04) (DN49 – EMPLOYEE MAILING STATE CODE)**
   Enter the state of the employee's mailing address.

9. Zip: **(Expected on FROI 04) (DN50 – EMPLOYEE MAILING POSTAL CODE)**
   Enter the postal code of the employee's mailing address.

10. Home Phone #: **(If Available) (DN51 – EMPLOYEE PHONE NUMBER)**
    Enter the employee's home telephone number, including area code.

11. Date of Injury: **(Mandatory) (DN31 – DATE OF INJURY)**
    Enter the date of the employee's injury.

12. Specific Injury or Illness: **(Expected on FROI 04) (DN35 – NATURE OF INJURY CODE)**
    Enter the title corresponding to the Nature of Injury Code.
    Values: see http://www.iaiabc.org/

13. Body Part(s) Affected: **(Expected on FROI 04) (DN36 – PART OF BODY INJURED CODE)**
    Enter the title corresponding to the Part of Body Injured Code.
    Values: see http://www.iaiabc.org/

14. Insurer/Claim Admin File #: **(Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)**
    Enter an identifier for a specific claim within the claim administrator's processing system.

15. Employer Name: **(Mandatory on FROI 04) (DN18 – EMPLOYER NAME)**
    Enter the legal name of the employer.

16. Employer Mailing Address and Phone #:
    DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected on FROI 04)
    DN165 – EMPLOYER MAILING CITY (Expected on FROI 04)
    DN170 – EMPLOYER MAILING STATE CODE (Expected on FROI 04)
    DN167 – EMPLOYER MAILING POSTAL CODE (Expected on FROI 04)
    DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER (If Available)
    Enter the primary mailing address, city, state, postal code, and phone number of the employer.

17. Insurer/Claim Admin Name: **(Expected) (DN188 – CLAIM ADMINISTRATOR NAME)**
Enter the legal name of the entity adjusting the claim.

Insurer/Claim Admin Address:
DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected on FROI 04)
DN12 – CLAIM ADMINISTRATOR CITY (Expected on FROI 04)
DN13 – CLAIM ADMINISTRATOR STATE CODE (Expected on FROI 04)
DN14 – CLAIM ADMINISTRATOR POSTAL CODE (Mandatory)
Enter the address, city, state, and postal code of the claim adjusting office handling the claim.

18. Insurer/Claim Admin FEIN: **(Mandatory) (DN187 – CLAIM ADMINISTRATOR FEIN)**
Enter the Federal Employer Identification Number of the entity licensed or allowed by a jurisdiction to adjust a claim.

19a. Full Denial Reason **(Mandatory on FROI 04 and SROI 04) (DN198 – FULL DENIAL REASON CODE)**
Enter the code(s) used to identify the reasons for denying a claim in its entirety.
Values (Enter no more than five):
1=No Compensable Accident (A,B,C,D,E,F,G or H)
2=No Causal Relationship (A,B,C,D,E or F)
3=No Coverage (A,B,C,D,E,F,G or H)
4=Substance Use/Abuse (A)
5=Other (not elsewhere classified) (A or C)

Full Denial Effective Date **(Mandatory on FROI 04 and SROI 04) (DN199 – FULL DENIAL EFFECTIVE DATE)**
Enter the date from which the claim administrator is denying all benefits for the claim.

19b. Partial Denial Reason **(Mandatory on SROI PD) (DN294 – PARTIAL DENIAL CODE)**
Enter a code identifying which portion of the claim is being denied.
Values:
A=Denying Indemnity in Whole, not Medical
B=Denying Indemnity in Part, not Medical
C=Denying Medical in Whole, Not Indemnity
D=Denying Medical in Part, Not Indemnity
E=Denying Indemnity in Whole, Medical in Part
F=Denying Medical in Whole, Indemnity in Part
G=Denying Both Indemnity & Medical in Part

20a. Date of Initial Incapacity **(Expected for Lost Time Claims) (DN56 – INITIAL DATE DISABILITY BEGAN)**
Enter the first day qualifying as a day of disability in the first period of disability. If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

Current Date of Incapacity **(If Applicable)** (**DN144 – CURRENT DATE DISABILITY BEGAN)**

Enter the first qualifying day of disability in the current period of disability being denied. If this date is the same as DN56, leave blank.

If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

20b. Date Employer Notified **(Mandatory for Lost Time Claims) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)**

Enter the date that the employer was notified or had knowledge of the employee's work-related disability/incapacity (DN56 or DN144 as applicable to this transaction).

21. Comments: **(If Applicable) (DN197 – DENIAL REASON NARRATIVE)**

Use this area to enter any additional information, explanations or clarifications.

PLEASE INCLUDE THE NAME AND CONTACT INFORMATION OF THE HEALH CARE PROVIDER IF THE DENIAL IS CONTROVERTING WHETHER A HEALTH CARE PROVIDER'S BILL IS REASONABLE AND PROPER UNDER SECTION 206.

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1,** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with Section 205(2) and in compliance with Section 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a denial and the payment of any accrued benefits.

23. Name: **(Expected on SROI 04 and SROI PD) (DN140 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE NAME)**

Enter the name of the individual working for the claim administrator that is responsible for handling the claim.

E-Mail Address: **(If Available) (DN138 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE E-MAIL ADDRESS)**

Enter the internet E-mail address of the individual responsible for handling the claim.

24. Telephone #: **(If Available) (DN137 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE BUSINESS PHONE NUMBER)**

Enter the telephone number of the individual responsible for handling the claim.

25. Date Sent to WCB: **(Mandatory) (DN100 – DATE TRANSMISSION SENT)**

Enter the actual date the batch of data was sent via EDI to the Board.

NOTES

LUMP SUM SETTLEMENT

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
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. PERMANENT IMPAIRMENT RATING _____ % AMOUNT PAID $_____

SOURCE OF RATING _____ DATE OF RATING _____

20. EXPECTED FUTURE MEDICAL COSTS RELATED TO THE INJURY: $ _____

21. COMMENTS:

22. EMPLOYER/INSURER REPRESENTATIVE (TYPE OR PRINT):	23. EMPLOYEE REPRESENTATIVE (TYPE OR PRINT):

RELEASE

24. EMPLOYEE/DEPENDENT:

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

_____ EMPLOYEE/DEPENDENT SIGNATURE _____ DATE _____ EMPLOYEE REPRESENTAIVE SIGNATURE _____ DATE

25. EMPLOYER/INSURER:

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

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

DECISION

26. THE REQUESTED SETTLEMENT (IS/IS NOT) APPROVED. THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT THE SETTLEMENT AMOUNT OF $ _____ AND ALL OUTSTANDING COMPENSATION OBLIGATIONS INCURRED PRIOR TO THE SETTLEMENT. PAYMENT MUST BE MADE WITHIN 10 DAYS PURSUANT TO 39-A M.R.S.A. 324(1). THE EMPLOYER/INSURER IS ORDERED TO PAY THE EMPLOYEE/DEPENDENT'S ATTORNEY A FEE OF $ _____. ALL PENDING PETITIONS BASED ON THIS CLAIM ARE HEREBY DISMISSED.

_____ HEARING OFFICER SIGNATURE _____ DATE

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-10 (eff. 1/1/13)

LUMP SUM SETTLEMENT, WCB-10

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

A Lump Sum Settlement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

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:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Type of Settlement

18. 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.

Permanent Impairment Rating

19. Enter the percentage of whole body permanent impairment rating, the amount paid, the source of the rating (Agreement of Parties, Decree, Mediation, Section 207 Exam, Section 312 Exam, or Treating Doctor), and the date of the rating.

Future Medical Costs

20. Enter the expected amount of future medical costs related to the injury.

Comments

21. Use this space to provide any comments.

Preparer Information

22. Employer/Insurer Representative
    Type or print the name of the employer/insurer representative.

23. Employee Representative
    Type or print the name of the employee representative.

Release

24. This box is for the employee/dependent and his/her representative to sign and date to consent to the lump sum settlement.

25. This box is for the employer/insurer and its representative (if applicable) to sign and date to consent to the lump sum settlement.

Decision

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

NOTES

STATEMENT OF COMPENSATION PAID

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. REASON FOR REPORT:

☐ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND) ☐ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

PAYMENT SUMMARY

19. LIST CUMULATIVE TOTALS (DO NOT INCLUDE ANY PENALTY AMOUNTS):

MEDICAL TREATMENT	$	DEATH BENEFIT/FUNERAL EXPENSE (NOT TO EXCEED $7,000.00)	$
WEEKLY COMPENSATION	$	LEGAL EXPENSE (EMPLOYEE RELATED)	$
PERMANENT IMPAIRMENT (PRE 1993 ONLY)	$	LEGAL EXPENSE (EMPLOYER RELATED)	$
EMPLOYMENT REHABILITATION	$	INTEREST AND OTHER PAYMENTS	$
LUMP SUM SETTLEMENT	$		
		TOTAL AMOUNT PAID (DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES)	**$**

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
24 STONE ST, STE 102	106 HOGAN RD	ONE VAUGHN PL	36 MOLLISON WAY	62 ELM ST
AUGUSTA, ME	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
04330-5220	04401-5638	CARIBOU, ME 04736	04240-7777	04101-3061
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

20. PREPARER NAME (TYPE OR PRINT): E-MAIL ADDRESS:	21. TELEPHONE NUMBER: ( ) TOLL-FREE NUMBER: ( )	22. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WCB-11 (eff. 1/1/13)

STATEMENT OF COMPENSATION PAID, WCB-11

Reporting Requirements

The initial Statement of Compensation Paid, Interim Report (WCB-11) shall be filed with the Board within 195 days of the date of an injury where indemnity payments have been made, and as a Final Report when no further payments are anticipated. Subsequent Statements of Compensation Paid (WCB-11) shall thereafter be filed with the Board within fifteen (15) days of each anniversary date of an injury when payments of any type have been made since the previous Statement of Compensation Paid (WCB-11). The Statement of Compensation Paid (WCB-11) is required when only medical payments are made subsequent to the filing of a Final Report. There is no requirement to file the Statement of Compensation Paid on claims when payments are made for medical only services and no indemnity was ever paid on the claim. See Rule 8.1.

Distribution

A Statement of Compensation Paid is a four-part form that is to be distributed as follows:

Copy 1 Workers' Compensation Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

Copy 2 Employee
Copy 3 Insurer
Copy 4 Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING STATEMENT OF COMPENSATION PAID, WCB-11

Identifying Information

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the insurer name as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the insurer mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

Payment Summary

18. □ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)

    □ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

    Check the box that describes the type of report being filed.

19. List Cumulative Totals:

- **Do not include any penalty amounts (<u>regardless of fault</u>).**
- **For cases involving apportionment, do not include amounts paid to the "lead" carrier.**
- **For cases involving salary continuation, do not include amounts paid by the employer.**
- **Do not reduce these totals by the amount of any recoveries, including deductibles.**

<u>Medical Treatment</u> – enter the sum of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids paid for this claim.

<u>Weekly Compensation</u> – enter the sum of indemnity benefits paid for this claim (NOTE: dependent benefits, benefits paid to the State resulting from the death of an employee when there is no person entitled to compensation, specific loss benefits, and mandatory payments are all considered weekly compensation benefits). **When filing this form as a Final Report, this amount must match the sum of the Amount Paid on all WCB-4, WCB-4A and mandatory Memorandum of Payment forms and/or the sum of the Compensation Payment to Date of Certificate and Compensation to be Paid for 21-Day Period on all WCB-8 forms.**

Permanent Impairment – enter the sum of permanent impairment benefits paid for this claim (pre 1993 claims only).

Employment Rehabilitation – enter the sum of employment rehabilitation expenses paid for this claim.

Lump Sum Settlement – enter the amount of any lump sum settlement approved by a Board Hearing Officer for this claim (include the amount of any Medicare Set-Aside).

Death Benefit/Funeral Expense – enter the sum of funeral expenses paid for this claim (cannot exceed $7,000.00).

Legal Expense (Employee Related) – enter the sum of the claimant's legal expenses paid for this claim.

Legal Expense (Employer Related) – enter the sum of the employer's legal expenses paid for this claim.

Interest and Other Payments – enter the sum of interest and all other payments not otherwise reported for this claim.

Total Paid - enter the total amount paid for all categories.

EXAMPLE: The following has been paid on a claim:

Payments to physicians	$ 500.00
Payments to hospitals	$1,000.00
Temporary Total Disability	$2,000.00

A $1,000.00 deductible has been recovered from the employer.

The amounts shown in box 19 should be as follows:

Medical	$1,500.00
Weekly Compensation	$2,000.00

Preparer Information

20. Preparer Name (Type or Print):
Enter the preparer's name.

E-Mail Address:
Enter the preparer's email address.

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

    Toll Free Number:
    Enter the preparer's toll free telephone number if one is available.

22. Date Mailed:
    Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL / HEALTH CARE INFORMATION

STATE OF MAINE
WORKERS'COMPENSATION BOARD

EMPLOYEE:_____ ADDRESS:_____

DATE OF INJURY:_____ SOCIAL SECURITY NUMBER:_____

BRIEF DESCRIPTION OF BODY PART(S) INJURED:_____

_____

_____

EMPLOYER:_____ ADDRESS:_____

INSURER:_____ ADDRESS:_____

ATTORNEY:_____ ADDRESS:_____

I hereby authorize the above employer, insurer, or their attorney to obtain from any hospital, physician, osteopath, chiropractor, or other health care provider, after payment to the provider of a reasonable fee, any written information only which is or has been prepared in connection with my examination or treatment regardless of date which relates to my _____(i.e. body part and/or condition) only. This certificate of authorization remains valid and must be honored for as long as I continue to make any claim for compensation, any compensation payment scheme remains in effect, or I receive compensation. This certificate of authorization does NOT permit the release of any information regarding psychological, substance abuse, sexually transmitted disease treatment, testing, or counseling and does NOT authorize oral communication with or by any health care provider.

_____ _____
EMPLOYEE SIGNATURE DATE

NOTICE TO THE EMPLOYEE

YOU HAVE 20 DAYS FROM RECEIPT OF THIS CERTIFICATE TO SIGN AND RETURN IT TO THE EMPLOYER OR INSURER. FAILURE TO SIGN AND RETURN THIS CERTIFICATE MAY RESULT IN A SUSPENSION OF ACTIVITY ON YOUR CLAIM FOR COMPENSATION, OR IF YOU ARE CURRENTLY RECEIVING COMPENSATION, YOUR PAYMENTS OF COMPENSATION MAY BE SUSPENDED UNTIL YOU SIGN AND RETURN THIS CERTIFICATE.

THIS IS THE AUTHORIZED FORM FOR THE RELEASE OF MEDICAL AND RELATED INFORMATION UNDER THE MAINE WORKERS' COMPENSATION ACT AND IS INTENDED TO SUPPLEMENT THE RIGHTS TO SECURE MEDICAL INFORMATION SET FORTH BY TITLE 39-A OF THE MAINE REVISED STATUTES ANNOTATED AND CHAPTER 12, SECTION 18 OF THE BOARD'S RULES AND REGULATIONS.

WCB-220 (eff. 1/1/13)

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL/HEALTH CARE INFORMATION, WCB-220

Filing Requirements

In the event that the employer/insurer contends that the medical records and information, pre-existing and subsequent to the workplace injury, for which claim is being made are relevant for determination of compensability and disability, it may obtain from the employee and the employee is obliged to within a reasonable time to execute the Limited Certificate Authorizing Written Release Of Medical/Health Care Information, WCB-220.

The employer/insurer must complete all informational areas of this form (except for Employee Signature and Date) before asking the employee to sign, date and return the form to them. This release in not valid without the employee's signature (or the signature of a person who has power of attorney for the injured employee).

Distribution

The Limited Certificate Authorizing Written Release of Medical/Health Care Information is a three-part form that is to be distributed 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 LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL/HEALTH CARE INFORMATION, WCB-220

Employee: _____

Enter the injured employee's name (first name, middle initial, last name).

Address: _____

Enter the employee's mailing address (street or P.O. Box, city, state and zip code).

Date of Injury: _____

Enter the date of the employee's injury. This date should be the same as box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Social Security Number: _____

Enter the employee's social security number.

Brief Description of Body Part(s) Injured: _____

Enter a list of the body parts affected by the injury or illness. When specifying a part of the body, be sure to indicate whether it is left or right. When the 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.)

Note: **The body part(s) must be identified.** This release applies only to medical/healthcare records that are related to the specific body part(s) or condition(s) listed on this form.

Employer: _____

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Address: _____

Enter the address where the employer receives mail. Also enter the employer's phone number, including area code.

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.

Address: _____

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

Attorney (Legal Representative): _____

If the employee is represented by a legal representative, enter the name of that legal representative.

Address: _____

Enter the legal representative's mailing address.

I hereby authorize the above employer, insurer, or their attorney to obtain from any hospital, physician, osteopath, chiropractor, or other health care provider, after payment to the provider of a reasonable fee, any written information only which is or has been prepared in connection with my examination or treatment regardless of date which relates to my _____ (i.e. body part and/or condition) only. This certificate of authorization remains valid and must be honored for as long as I continue to make any claim for compensation, any compensation payment scheme remains in effect, or I receive compensation. This certificate of authorization does NOT permit the release of any information regarding psychological, substance abuse, sexually transmitted disease treatment, testing, or counseling and does NOT authorize oral communication with or by any health care provider.

_____ _____

Employee Signature Date

The injured employee, or a person who holds power of attorney for the employee, **must** sign the first line and enter the date of their signature on the second line.

NOTES

EMPLOYMENT STATUS REPORT

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

PART I (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER

ANY EMPLOYER REQUESTING A QUARTERLY REPORT MUST PROVIDE THE EMPLOYEE WITH THIS FORM AT LEAST 15 DAYS PRIOR TO THE DATE ON WHICH THE REPORT IS DUE , PURSUANT TO 39-A M.R.S.A. §308(2).

19.

NOTICE TO EMPLOYEE

COMPLETE BOXES 20 AND 21AND RETURN THIS REPORT TO THE EMPLOYER LISTED ABOVE. FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT YOUR WORKERS' COMPENSATION INDEMNITY BENEFITS.

THIS REPORT IS DUE: _____

THIS REPORT COVERS THE PERIOD FROM _____TO _____

PART II (COMPLETED BY THE EMPLOYEE)

20.

A. HAVE YOU BEEN EMPLOYED, CHANGED EMPLOYMENT OR PERFORMED ANY SERVICES FOR COMPENSATION DURING THE PERIOD STATED IN THE ABOVE SECTION?

YES ☐ NO ☐

B. IF YES, COMPLETE THE FOLLOWING FOR EACH EMPLOYER AND ATTACH VERIFICATION OF INCOME:

EMPLOYER NAME: _____ TELEPHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NATURE OF THE EMPLOYMENT OR SERVICES _____

EMPLOYED FROM: _____ TO _____

ARE YOU STILL EMPLOYED? YES ☐ NO ☐

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

_____ _____
EMPLOYEE SIGNATURE DATE

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-230 (eff. 1/1/13)

EMPLOYMENT STATUS REPORT, WCB-230

Reporting Requirements

Pursuant to Section 308(2), at the previous employer's request, any person receiving compensation under this Act who has not returned to that person's previous employment must submit quarterly employment status reports to that employer. The report is due 90 days after the date of injury, or after the filing of the report and every 90 days thereafter. Any employer requesting a quarterly report must provide the employee with the prescribed form at least 15 days prior to the date on which it is due.

Distribution

Pursuant to Rule 1.8, the Employment Status Report is a three-part form that is to be distributed 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

Part I Completed By Employer/Insurer

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

Notice to Employer

18. This section notifies the employer when to send this form to the employee. Employer must complete the information in box 19 for the employee notice.

Notice to Employee

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

This Report is Due: Employer must enter the date the report is due.

This Report Covers the Period From _____ to _____: Employer must enter the from and to dates covered by this report.

Part II Completed By The Employee

20A. Have you been employed, changed employment or performed any services for compensation during the period stated in box 19?
Check either Yes or No.

20B. If Yes is checked, complete this section with the name, address, and telephone number(s), nature of employment and dates of employment for each new employer(s). (Use reverse side of report, if necessary.) **Attach verification of income from each new employer.**

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

NOTES

EMPLOYEE'S RETURN TO WORK REPORT

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

PART I (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THE EMPLOYER/INSURER SHALL SEND THE EMPLOYEE'S RETURN TO WORK REPORT TO THE EMPLOYEE WHEN FILING THE MEMORANDUM OF PAYMENT PURSUANT TO 90 MAR 351 CH. 8. §17.

19.

NOTICE TO EMPLOYEE

IF YOU RETURN TO WORK WITH A NEW EMPLOYER, COMPLETE BOXES 20 AND 21 AND FILE COPIES OF THIS REPORT WITH THE BOARD AND YOUR PREVIOUS EMPLOYER AT THE ADDRESSES LISTED ABOVE WIITHIN 7 DAYS PURSUANT TO 39-A M.R.S.A. §308(1).

FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT YOUR WORKERS' COMPENSATION INDEMNITY BENEFITS.

PART II (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

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-231 (eff. 1/1/13)

EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

Reporting Requirements

Pursuant to Section 308(1), any person receiving compensation under this Act who returns to employment or engages in new employment after that person's injury shall file a written report of that employment with the Board and that person's previous employer within 7 days of that person's return to work. This report must include the identity of the employee, the employee's employer and the amount of weekly wages or earnings received or to be received by the employee.

Per Rule 8.17, the employer/insurer shall send the Employee's Return to Work Report to the employee when filing the Memorandum of Payment, WCB-3, pursuant to Section 205(7).

Distribution

The Employee's Return to Work Report is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board
27 State House Station
Augusta, Maine 04333-0027

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

Part I Completed By Employer/Insurer

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
    Enter a brief description of the injury or illness.

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 or his or her responsibilities.

Part II 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.

NOTES

EMPLOYEE'S RETURN TO WORK REPORT

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

PART 1 (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER XXX-XX-		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:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18.

NOTICE TO EMPLOYER/INSURER

THIS REPORT IS SENT TO THE EMPLOYEE WITH THE 21-DAY CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION OR THE PETITION FOR REVIEW PURSUANT TO RULE 8.15.

19.

NOTICE TO EMPLOYEE

YOUR WEEKLY BENEFITS WILL BE REDUCED OR DISCONTINUED EACH WEEK TO THE AMOUNT SHOWN ON THE CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION OR PETITION FOR REVIEW. YOU ARE REQUIRED TO PROVIDE DOCUMENTATION TO THE INSURER OF YOUR WEEKLY EARNINGS FOR THE 21-DAY PERIOD OR WHILE THE PETITION FOR REVIEW IS PENDING BEFORE THE WORKERS' COMPENSATION BOARD BY COMPLETING THE INFORMATION IN BOX 20 BELOW. IF YOU FAIL TO PROVIDE DOCUMENTATION, THE REDUCTION SHOWN ON THE CERTIFICATE OF DISCONTINANCE OR REDUCTION OR PETITION FOR REVIEW SHALL REMAIN IN EFFECT AND YOUR BENEFITS WILL NOT BE ADJUSTED.

PART 2 (COMPLETED BY THE EMPLOYEE)

20. **COMPLETE THE FOLLOWING INFORMATION.**

A. INCOME FROM NEW EMPLOYMENT (attach verification):

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

PAY PERIOD ENDING DATE _____ AMOUNT _____

B. COMMENTS:

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

_____ _____
EMPLOYEE SIGNATURE DATE

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-231A (eff. 1/1/13)

EMPLOYEE'S RETURN TO WORK REPORT, WCB-231A

Reporting Requirements

Reduction or discontinuance pursuant to §205(9)(B)(1): Pursuant to Rule 8.15, the employer/insurer must include form WCB-231A (Employee's Return to Work Report) with the 21-day Certificate of Discontinuance or Reduction. Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

Reduction or discontinuance pursuant to § 205(9)(B)(2): Pursuant to Rule 8.15, the employer/insurer shall send to the employee form WCB-231A (Employee's Return to Work Report) in addition to the Petition for Review. The employer/insurer shall file the actual documented earnings and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review. Thereafter, the employer/insurer shall, within 30 days after receipt of the actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4.

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

Part I Completed By The Employer/Insurer

1. Insurer File Number:
   Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:
   Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address or Phone Number:
   Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:
   Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:
   Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:
   Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:
   Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:
   Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:
   Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:
    Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address –Number and Street:
    Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:
    Enter the city of employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:
    Enter the state of employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:
    Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone:
    Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:
    Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:
Enter a brief description of the injury or illness.

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 or his or her responsibilities.

Part II Completed By The Employee

20. Complete this section, supplying the following information:
    A. Pay period ending date and amount of gross wages earned.
    B. Use this space to provide any comments.

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

NOTES