PETITION FOR REVIEW OF EXTENDED BENEFITS AWARDED DUE TO EXTREME FINANCIAL HARDSHIP PURSUANT TO 39-A M.R.S.A. §213(1)(B)

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

EMPLOYER

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____

INSURER

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____

EMPLOYEE

NAME: _____
STREET/P.O. BOX: _____
CITY, STATE, ZIP: _____
TELEPHONE NUMBER: _____

SOCIAL SECURITY NUMBER: XXX-XX-_____
(only last four digits required)

BOARD FILE NUMBER: _____

1. Compensation of $ _____ per week is being paid for partial incapacity.
2. Since the order extending benefits dated _____, there has been a material change in the employee's circumstances; specifically:
   (MONTH DAY YEAR)

_____
_____
_____
_____
_____

THEREFORE, the petitioner asks the board to reduce/discontinue the employee's extended benefits pursuant to 39-A M.R.S.A. §213(1)(B).

_____
SIGNATURE OF PETITIONER

DATED: _____
MONTH DAY YEAR

FILING INSTRUCTIONS

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to each other party listed on the petition.
3. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

_____
NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

_____
STREET/P.O. BOX

_____
CITY, STATE, ZIP

_____
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: (888) 801-9087 or TTY Maine Relay 711.
WCB-213A (eff. 1/1/13)