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/INSURER

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 WITHOUT PREJUDICE.

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:	22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET:	23. DATE OF INCAPACITY:	24. DATE CHECK MAILED:	25. AVERAGE WEEKLY WAGE:
A. ☐ WEEKLY COMPENSATION B. ☐ SPECIFIC LOSS: _____ WEEKS C. ☐ SALARY CONTINUATION D. ☐ OTHER (EXPLAIN):_____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY DATE EMPLOYER NOTIFIED OF INCAPACITY: _____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY	$ _____

26. WEEKLY CHECK AMOUNT (NET):

$ _____

(IF VARYING RATES ARE BEING PAID, ENTER THE WORD "VARYING")

BENEFIT TYPE:

A. ☐ TOTAL INCAPACITY (§212)

B. ☐ PARTIAL INCAPACITY (§213)

C. ☐ FATAL (§215/§355 (14) (F))

27. WEEKLY CHECK REDUCED FOR:

A. ☐	3rd PARTY LIABILITY (§107)	$_____
B. ☐	EARNINGS ((§213(1))	$_____
C. ☐	UNEMPLOYMENT COMPENSATION (§220)	$_____
D. ☐	SOCIAL SECURITY RETIREMENT (§221(3)(A)(1))	$_____
E. ☐	PAID TIME OFF (§221(3)(A)(2))	$_____
F. ☐	WAGE CONTINUATION PLAN (§221(3)(A)(2))	$_____
G. ☐	DISABILITY INSURANCE (§221(3)(A)(3))	$_____
H. ☐	EMPLOYER FUNDED PENSION (§ 221(3)(A)(5))	$_____
I. ☐	APPORTIONMENT (§ 354)	$_____
J. ☐	OTHER:_____	$_____
K. ☐	NOT APPLICABLE	

27a. IF THIS IS AN APPORTIONMENT CLAIM, PLEASE COMPLETE 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
442 CIVIC CTR. DRIVE, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	56 NORTHPORT DR, STE 201 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

29. PREPARER NAME (REQUIRED):	30. TELEPHONE NUMBER (REQUIRED):	31. DATE MAILED:
E-MAIL ADDRESS (REQUIRED):	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.