

**COMPLAINT FOR PENALTIES  
PURSUANT TO 39-A §205(3)**

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

**PETITIONER - EMPLOYEE**

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_  
(last four digits required)  
BOARD FILE NUMBER: \_\_\_\_\_

**RESPONDENT - EMPLOYER**

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

**RESPONDENT - INSURER**

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

**NOTICE**

A party is not required to file a written response to this petition. 39-A M.R.S.A. §307(3).

1. On \_\_\_\_\_, \_\_\_\_\_ sustained a  
MONTH DAY YEAR EMPLOYEE NAME  
work-related injury while working for \_\_\_\_\_.  
EMPLOYER NAME

2. On \_\_\_\_\_, the employer had notice or knowledge of the work-related injury.  
MONTH DAY YEAR  
Incapacity (lost time from work) began on \_\_\_\_\_.  
MONTH DAY YEAR

3. **[CHECK ONE]:**

- There is no ongoing dispute regarding the claim and the insurer/employer has failed to pay weekly compensation benefits within thirty (30) days after becoming due and payable; OR
- The insurer/employer failed to deny the claim within fourteen (14) days after notice or knowledge of the injury and has failed to pay weekly compensation benefits within thirty (30) days of becoming due and payable.

**THEREFORE**, I request such penalties as I may be entitled pursuant to Title 39-A §205(3).

DATED: \_\_\_\_\_  
MONTH DAY YEAR

\_\_\_\_\_  
SIGNATURE OF PETITIONER

**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 named in the petition **AND** if it is not a party, mail one (1) copy to the employer, employers' insurer or group self-insurer.
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-280 (eff. 1/1/13)