State of Maine

Workers' Compensation Board

Forms Training Mini-Manual

The general mission of the Maine Workers' Compensation Board is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.

Disclaimer

This document was prepared as a supplement to the training and outreach efforts and programs of the Maine Workers' Compensation Board. Its purpose is simply to address some of the more common misunderstandings, errors, and ambiguities encountered by employers, insurers, claim administrators, and employees of the Board in the course of their duties.

Maine WC Law, Rules, blank forms, WC Board newsletters, Compliance Reports, training modules, and other Board information may be found online at www.maine.gov/wcb.

Additional resources from the Maine Workers' Compensation Board

You will find many valuable resources on our website, including all Board forms in fillable PDF format, EDI information, laws, rules, newsletters, compliance reports, training modules, benefit tables, fee schedules, and regional office locations.

www.Maine.gov/wcb

PAGE	BOARD FORM		STATUTES	RULES	FILING REQUIREMENTS
5	WCB-1	First Report of Injury	§ 303	§ 1.7 § 8.13 § 3.1 § 8.16 § 3.4	Filed electronically within 7 days' notice/knowledge of a lost day.
7	WCB-2	Wage Statement	§ 153(4) § 205(8) § 303	§ 1.7	Filed within 30 days' notice/knowledge of a claim for compensation.
N/A	WCB-2.1	Comparable Wage Statement	§ 102(4)(D)		Optional
9	WCB-2B	Fringe Benefits Worksheet	§ 303	§ 1.7 § 8.9	Filed within 30 days' notice/knowledge of a claim for compensation.
11	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.
15	WCB-3A	Memorandum of One-Time Payment	§ 153(1)(B) § 205(7) §205(9)(A)	§ 1.1 § 8.11 §1.7 § 8.12	Optional
17	WCB-4D	Discontinuance of Compensation	§ 205(9)(A)	§ 1.7 § 8.11 § 8.12	Filed within 14 days after benefits are discontinued pursuant to 39-A M.R.S.A. §205(9)(A).
19	WCB-4M	Modification of Compensation	§ 205(9)(A)	§ 1.7 § 8.11 § 8.12	Filed within 14 days after benefits are reduced pursuant to 39-A M.R.S.A. §205(9)(A).
21	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.
24	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).
27	WCB-9	Notice of Controversy	§ 313(1)	§ 1.1 § 8.2 § 1.7 § 8.12 § 3.4	Filed electronically within 14 days of claim for incapacity or death benefits.
29	WCB-10	Lump Sum Settlement	§ 352	§ 12.18	File for the board's approval to commute all payments for future benefits to a lump sum.
32	WCB-11A and 11B (optional)	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.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

(Note: the DN numbers represent a crosswalk to the IAIABC Claims EDI data elements.)

1. WCB FILE NUMBER (if known): DN5

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

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS DN74 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO DN66

3. ☐ LOST EARNINGS BUT NO LOST TIME NA 4. ☐ MEDICAL/HEALTH CARE DN74 5. ☐ FATALITY DATE OF DEATH: ____/____/____ DN57 Also see DN146 MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE DN290 6b. DATE OF LAST EXPOSURE: ____/____/____ DN31 MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ NA MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT DN2 7b. DATE OF CORRECTION: ____/____/____ DN3 MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ DN3 MM DD YYYY

Note: also see correction process & DN295, 296

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): DN329	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): DN16	10. EMPLOYER NAME: DN18		
11. STREET/P.O BOX MAILING ADDRESS: DN168-169	12. CITY: DN165	13. STATE: DN170	14. ZIP: DN167	15. TELEPHONE NUMBER: DN159 ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: DN25	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: DN19-23 EMPLOYER PHYSICAL COUNTRY CODE = DN164	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO DN249 IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: DN120, 119, 122, 121, 123, 33, 118 ACCIDENT SITE COUNTRY CODE = DN280		

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

19. INSURANCE / TPA COMPANY NAME: DN7/188	20. POLICY NUMBER: DN28	21. INSURER FILE NUMBER: DN15		
22. STREET/P.O. BOX MAILING ADDRESS: DN10-11	23. CITY: DN12	24. STATE: DN13	25. ZIP: DN14	26. TELEPHONE NUMBER: NA ( )

27. LAST NAME: DN43 & DN255	28. FIRST NAME: DN44	29. MI: DN45	30. TELEPHONE NUMBER:( ) DN51	31. SOCIAL SECURITY NUMBER: DN42	32. GENDER: DN53 ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS: DN46-47	34. CITY: DN48		35. STATE: DN49	36. ZIP: DN50	37. DATE OF BIRTH: DN52 ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE: DN60	39. DATE OF HIRE: DN61 ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $ DN62		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO NA IF YES, GIVE NAME AND ADDRESS: NA	

42. DATE OF INJURY OR ILLNESS: ____/____/____ DN31 MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ DN40 MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ DN56 MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ DN281 MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): NA 46. TIME OF INJURY (e.g. 1:10 p.m.): DN32	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ DN41 MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO DN189 IF YES, GIVE DATE: ____/____/____ DN68 MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): DN35	49. BODY PART(s) AFFECTED (e.g. lower right forearm): DN36	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): DN37
51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): NA	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.): DN38	

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO DN39	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO DN39	55. HEALTH CARE PROVIDER NAME: NA	56. MAILING ADDRESS: NA	57. TELEPHONE NUMBER: NA

58. PREPARER NAME AND TITLE (TYPE OR PRINT): DN140	59. TELEPHONE NUMBER: DN137 ( )	60. DATE SENT TO WCB: DN100 ____/____/____ MM DD YYYY

WCB-1 (01/02) 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 material can be made available in alternate formats by contacting your Department ADA Coordinator.
DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER.

WCB-1 Employers' First Report of Occupational Injury or Disease (FROI):

Due Date - File electronically using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format within seven days of notice/knowledge of a work-related injury which has caused the employee to lose a day's work

Box 2b - Was employee paid for ½ day on day of injury? - Make sure this is accurate! It affects the calculation of the waiting period, compensability, and indemnity benefits. (If paid for ½ day or more, the date of injury is NOT a compensable day of incapacity).

Box 42 - Date of injury or illness

- Date of injury - date injury occurred (traumatic injury) or date of last injurious exposure (cumulative injury or occupational disease).
- Date employer notified - the date the employer had notice or knowledge of the injury.

Box 43 - Date of incapacity

- Date of incapacity - the date that meets the definition of a day for purposes of filing a First Report of Occupational Injury or Illness (WCB-1) under § 303.
- Date employer notified – the date the employer had notice or knowledge of the date of incapacity as defined above.

Box 45 - Date employer notified insurer - Earliest date the claim administrator had notice of the injury from any source. (For most filing/payment deadlines, the day employer had notice or knowledge starts the clock ticking regardless of when the claim administrator was notified).

Box 47 - Has employee returned to work? - If days lost are less than or equal to 7, the actual RTW date must be reported within 7 days of the employee's RTW with a FROI 02 transaction. The RTW date is not required if more than 7 days lost.

General

- Employers must report ALL injuries to their insurance carrier, including medical only injuries.
- The definition of a lost-time claim is "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" (See § 303).
- Once the claim type has been established as a lost time claim (claim status codes W, P, I, or L), the claim type code should never be changed to N, M, or B; doing so will affect your compliance measurements.
- Lost-time FROIs should memorialize the initial incapacity; do NOT update the FROI for subsequent periods of incapacity.

1. REVISION DATE:	**WAGE STATEMENT**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PART(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

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. Does employee work concurrently? ☐ Yes ☐ No If yes, a Wage Statement must be submitted for each employer.

Names: (1)_____ (2)_____ (3)_____

21. Method of Calculation:
☐ 102(4)(A) – Salaried
☐ 102(4)(B) – Varying Wages
☐ 102(4)(C) – Seasonal Worker
☐ 102(4)(D) – Other*

* You must submit a minimum of 2 comparable Wage Statements with this filing and provide a detailed explanation of the calculation.

22. 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			**23. TOTAL EARNINGS**		$
18			36			**24. GROSS AVERAGE WEEKLY WAGE**		$

COMMENTS:

25. PREPARER'S FULL NAME (REQUIRED):	26. TELEPHONE NUMBER (REQUIRED):	27. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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 (Effective 6-1-2026)

WCB-2 Wage Statement:

Due Date - Within 30 days of notice/knowledge of a claim for compensation. (Box 22 of the MOP or Box 21b. of the NOC).

Box 20 - Concurrent employer - Obtain separate wage statements for each employer. The employer for whom the employee worked at the time of injury is required to obtain and file the WCB-2(s) from the other employer(s). A concurrent employer is one who the employee had an employment relationship with at the time of the injury, whether or not they were actually working for them.

Box 22 - Gross wages for each week

- Must be actual earnings, estimates are not accepted.
- If the employee is paid on other than a weekly basis, the form may be filled out on that basis (bi- weekly, monthly, etc.). However, actual earnings must be shown for week 1 of a bi-weekly payroll, the week of hire (if applicable) and the week of injury, as well as any weeks with NO earnings. Bi-weekly amounts divided by 2 rather than actual earnings will be flagged as an issue.
- Include reported tips for tipped employees.
- Use payroll week ending dates, not check issue dates.
- Must be completed even if worksheet attached.
- Week 52 is the week that includes the injury; work backward to week 1.
- Include all weeks, even if there are no earnings. Do not include more than 52 weeks.

Box 23 - Total earnings - This must be the total of all earnings for the 52 week period (even if not all earnings are used in calculating the AWW), otherwise it will be flagged as an issue.

Box 24 - Gross average weekly wage – This must be the average weekly wage calculated in accordance with the method indicated in Box 21, otherwise it will be flagged as an issue. Please include your calculation in the comments.

General

- Remember the "Buddy System". Be sure to review any wage statements completed by the employer BEFORE submission to the Board.

1. REVISION DATE:	**FRINGE BENEFITS WORKSHEET**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE				
3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	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

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

Form Instructions:

(1) For each Fringe Benefit listed on the form, indicate if the benefit is provided.
- If the benefit is provided at no cost to the employer, "No" may be selected.

(2) For each Fringe Benefit provided, indicate if the benefit continues while the employee is out of work.

(3) For each Fringe Benefit that does not continue, provide a date the benefit ends and the weekly cost of the benefit.
- If the date is unknown, "TBD" or "Unknown" are acceptable.
- A percentage may be submitted in lieu of a dollar amount for a 401K fringe benefit.

20. Fringe Benefit	Is the Fringe Benefit provided?	Does the benefit continue while the employee is out of work?	Date Benefit Ends	Weekly Cost to Employer
Health Benefits (incl. insurance)	Yes ☐ No ☐	Yes ☐ No ☐		
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐		
Disability Insurance (inc. 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 ☐		

21. TYPE OR PRINT PREPARER NAME (REQUIRED):	22. TELEPHONE NUMBER (REQUIRED):	23. DATE SENT TO WCB :
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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 (Effective 6-1-2026)

WCB-2B Fringe Benefits Worksheet:

Due Date - Within 30 days of notice/knowledge of a claim for compensation. (Box 22 of MOP or Box 21b. of NOC.)

Box 20 - 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 their date of injury (see Rule 1.5.1). NOTE: the amounts reported are subject to verification by the employee and their representative and documentation must be provided upon request.

General

- The WCB-2B is required to accompany ALL Wage Statements (WCB-2) filed on or after 1/1/2013, regardless of date of injury.
- A WCB-2B is required to be filed for concurrent employers, as well as the employer of injury.
- Any benefit checked as "yes" in the "provided" column must also be checked "yes" or "no" in the "continues" column.
- Any benefit checked “no” in the continues column, must have a date the benefit ends and a dollar amount in the cost column. If the date the benefit ends is unknown, “TBD” or “Unknown” are acceptable. Also a percentage may be submitted in lieu of a dollar amount in the case of a 401(k).
- Per change effective 9/1/18 to Rule 1.5.1.A.3, inclusion of 401(k), 403(b) and equivalent plans ends when the employee returns to work.
- Remember the “Buddy System”. Be sure to review any worksheets completed by the employer BEFORE submission to the Board.

1.REVISION DATE:	**MEMORANDUM OF PAYMENT**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PART(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

The first payment of your workers' compensation weekly compensation payments has been made.

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. Payment is made for the following reason (choose one):

- ☐ Your claim is accepted
- ☐ This is a Voluntary Payment (Payment Without Prejudice)
- ☐ This is a mandatory payment per Rule 1.1 From: Through: Amount Paid: $

21. Payment Type (choose one):

- ☐ Weekly Compensation
- ☐ Specific Loss (Body Part(s)): Weeks:
- ☐ Salary Continuation (Employer paying at/above AWW; insurer not paying any benefits at this time)
- ☐ Other (Explain):

22. First day of compensability after waiting period was met:	23. Date of Incapacity: Date Employer Notified:	24. Date of Initial Payment:
25. Average Weekly Wage: $ Compensation Rate: $	26. Benefit Type: ☐ Total Incapacity (§212) ☐ Partial Incapacity (§213) ☐ Fatal (§215/§355(14)(F))	27. Weekly Net Amount: ☐ Fixed* $ *Salary Continuation amount or rate minus offsets, if any ☐ Varying

27A. Offsets:

☐ Apportionment (§354)	$	☐ Social Security Retirement (§221(3)(A)(1))	$
☐ Disability Insurance (§§221(3)(A)(2)-(3))	$	☐ Third Party Liability (§107)	$
☐ Earnings from Same Employer	$	☐ Unemployment Compensation (§220)	$
☐ Employer Funded Pension (§ 221(3)(A)(5))	$	☐ Wage Continuation Plan (§221(3)(A)(2))	$
☐ Paid Time Off (§§221(3)(A)(2))	$	☐ Other:	$

Comments:

28. PREPARER'S FULL NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	29. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	30. DATE SENT TO WCB: WCB USE ONLY:

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WCB-3 (Effective 6-1-2026)

WCB-3 Memorandum of Payment (MOP):

Due Date - Within 14 days of notice/knowledge of incapacity or 6 days from Box 22 of MOP (non-consecutive period).

Box 20- Reason for payment –

- Your claim is accepted - Checking "Your claim is accepted" creates a "compensation scheme" (payment with prejudice). In general, unless the employee returns to work or receives an increase in pay from the employer of injury, a petition must be filed to reduce or discontinue benefits and benefits may not be reduced or discontinued until the matter has been resolved by a decree issued by an administrative law judge. See § 205.9(B)(2) for exceptions.
- This is a voluntary payment (payment without prejudice). This option allows a claim administrator to initiate benefits without officially accepting liability for the injury.
- This is a mandatory payment per Rule 1.1. If the claim administrator fails to accept the claim and file a MOP, pay without prejudice and file a MOP, or deny the claim and file a NOC within 14 days of notice or knowledge of a claim for incapacity or death benefits for a work-related injury, the claim administrator must make a mandatory payment in accordance with the rule.

Box 21-Payment Type

- Weekly Compensation – includes most payment of compensation for incapacity (this includes but is not limited to compensation for incapacity paid pursuant to an agreement of the parties or Board decision).
- Salary Continuation – The amount of salary must equal or exceed the employee's average weekly wage. If the amount of salary is not sufficient, the MOP must be filed as Weekly Compensation with an offset for the amount of the earnings/salary.
- If "specific loss" is checked, list the body parts affected and enter the number of weeks payable.
- "Other" should be extremely rare. If "other" is checked, describe the type of payment:
    - Permanent Impairment (pre-1993 claims)
    - Disfigurement (pre-1993 claims)
    - Occupational disease (pre-1993 claims)
    - Occupational hearing loss (§ 612)
    - Death of any employee when there is no person entitled to compensation (§ 355(14)(F))

Box 22 - First day of compensability

- The date that the employee was incapacitated beyond the waiting period and/or was entitled to indemnity benefits (sometimes referred to as "day 8").
- Complete if current incapacity is subject to 7 day waiting period or employee is a firefighter. Need not be completed for subsequent periods of incapacity from the same injury.
- For salary continuation, complete as if the employee has lost the wage that is being continued during the time absent, or when the hours missed equals hours in a regular work week.
- For partial incapacity, waiting period may be determined by lost wages (AWW method) or lost benefits (WCR method). Other methods may be acceptable.

Box 23

- **Date of Incapacity** - must be the first day the employee lost any time or wages as a result of the injury for the period of incapacity being reported (even if it is not compensable, i.e. the initial incapacity did not continue for more than 14 days).

  Exception: When an employee is paid 1/2 day or more wages on the date of injury, the date of injury will not be considered a day of incapacity (see Board Rules Chapter 8, Section 3).
- **Date Employer Notified of Incapacity** - Should not pre-date the date of incapacity above.

Box 24 - Date of Initial Payment - the date the initial benefit payment is mailed or electronically disbursed.

Box 25

- Average Weekly Wage – this should match the wage reported in Box 24 of the wage statement unless there is an agreement of the parties or decision of the Board that supersedes the amount.
- Compensation Rate – this is the compensation rate calculated in accordance with the applicable statute. For dates of injury on or after January 1, 2013, this rate must be equal to 2/3 of the employee's average weekly wage.

Box 27 – Weekly Net Amount

- Check the fixed box if the employee will be paid a fixed amount each week.
- If fixed is selected, enter the applicable dollar amount:
  - In the case of weekly compensation this is the compensation rate (or the applicable maximum) after offsets.
  - For cases involving salary continuation, enter the amount of the salary being paid by the employer.

Box 27A. Offsets - Do not check Earnings from Same Employer, Paid Time Off, and/or Wage Continuation Plan for varying rates.

General

- Must be “closed” with a discontinuance via form WCB-4A, WCB-4D, or WCB-8.
- If a provisional MOP was filed initially and the actual rate is greater than the provisional rate, an amended MOP should be filed to establish the correct average weekly wage and weekly compensation rate.

1.REVISION DATE:	**MEMORANDUM OF ONE-TIME PAYMENT**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PART(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

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20. PAYMENT IS MADE FOR THE FOLLOWING REASON (CHOOSE ONE):

☐ Administrative Law Judge (ALJ) decree (closed-end period)	Date of Decree
☐ Consent Decree (closed-end period)	Date Signed By ALJ:
☐ Death No Dependents (payment to the State)	Date of Death:
☐ Disfigurement (Pre-1993 claims only) Body Part:	Weeks:
☐ Mandatory Payment Per Rule 1.1	Date NOC Filed:
☐ Mediation Agreement (closed-end period)	Date of Mediation:
☐ Occupational Loss of Hearing	Weeks:
☐ Permanent Impairment (pre-1993 claims only) Body Part:	Weeks:

	PAYMENT FROM	PAYMENT THROUGH	BENEFIT TYPE	WEEKLY NET AMOUNT	AMOUNT PAID
1			☐ TOTAL INCAPACITY (§212) ☐ PARTIAL INCAPACITY (§213 ☐ FATAL (§215/§355 (14) (F))	☐ FIXED RATE $ ☐ VARYING RATE	$
2			☐ TOTAL INCAPACITY (§212) ☐ PARTIAL INCAPACITY (§213 ☐ FATAL (§215/§355 (14) (F))	☐ FIXED RATE $ ☐ VARYING RATE	$
3			☐ TOTAL INCAPACITY (§212) ☐ PARTIAL INCAPACITY (§213 ☐ FATAL (§215/§355 (14) (F))	☐ FIXED RATE $ ☐ VARYING RATE	$
4			☐ TOTAL INCAPACITY (§212) ☐ PARTIAL INCAPACITY (§213 ☐ FATAL (§215/§355 (14) (F))	☐ FIXED RATE $ ☐ VARYING RATE	$
5			☐ TOTAL INCAPACITY (§212) ☐ PARTIAL INCAPACITY (§213 ☐ FATAL (§215/§355 (14) (F))	☐ FIXED RATE $ ☐ VARYING RATE	$

21. Total Amount Paid $	22. Date of Payment:

Terms/Comments:

23. PREPARER'S FULL NAME (REQUIRED):	24. TELEPHONE NUMBER (REQUIRED):	25. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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-3A (Effective 6-1-2026)

WCB-3A Memorandum of One-Time Payment:

Due Date – Form is optional. No specific due date for the form itself, but payment is due within 10 days after the receipt of notice of an approved agreement for payment of compensation or within 10 days after any order or decision of the board awarding compensation.

Box 20- Reason for payment –

Example: THEREFORE, Employee's PETITION FOR AWARD is granted, in part; Employer/Insurer is ordered to pay total incapacity benefits (pursuant to 39-A M.R.S.A. §212) from December 19, 2023 through January 21, 2024, and from July 1 through October 18, 2024; partial incapacity benefits (pursuant to 39-A M.R.S.A. §213) based on the difference between her average weekly wage and her actual earnings with Employer from January 22 through June 30, 2024; and partial incapacity benefits (pursuant to 39-A M.R.S.A. §213) based on an imputed earning capacity of $200.00 per week from October 19, 2024 to the present and continuing.

	PAYMENT FROM	PAYMENT THROUGH	BENEFIT TYPE	WEEKLY NET AMOUNT	AMOUNT PAID
1	12/16/2023	01/21/2024	(•) TOTAL INCAPACITY (§212) ( ) PARTIAL INCAPACITY (§213 ( ) FATAL (§215/§355 (14) (F))	(•) FIXED RATE $ 300.00 ( ) VARYING RATE	$ 1,457.14
2	01/22/2024	06/30/2024	( ) TOTAL INCAPACITY (§212) (•) PARTIAL INCAPACITY (§213 ( ) FATAL (§215/§355 (14) (F))	( ) FIXED RATE $ (•) VARYING RATE	$ 2,530.00
3	07/01/2024	10/18/2024	(•) TOTAL INCAPACITY (§212) ( ) PARTIAL INCAPACITY (§213 ( ) FATAL (§215/§355 (14) (F))	(•) FIXED RATE $ 300.00 ( ) VARYING RATE	$ 4,714.29
4			( ) TOTAL INCAPACITY (§212) ( ) PARTIAL INCAPACITY (§213 ( ) FATAL (§215/§355 (14) (F))	( ) FIXED RATE $ ( ) VARYING RATE	$
5			( ) TOTAL INCAPACITY (§212) ( ) PARTIAL INCAPACITY (§213 ( ) FATAL (§215/§355 (14) (F))	( ) FIXED RATE $ ( ) VARYING RATE	$
21. Total Amount Paid $ 8,701.43				22. Date of Payment: 03/22/2026	
Terms/Comments: Employer/Insurer is ordered to pay total incapacity benefits (pursuant to 39-A M.R.S.A. §212) from December 19, 2023 through January 21, 2024, and from July 1 through October 18, 2024; partial incapacity benefits (pursuant to 39-A M.R.S.A. §213) based on the difference between her average weekly wage and her actual earnings with Employer from January 22 through June 30, 2024; and partial incapacity benefits (pursuant to 39-A M.R.S.A. §213) based on an imputed earning capacity of $200.00 per week from October 19, 2024 to the present and continuing.					

General

- May substitute for MOP, WCB-4M (if applicable), and WCB-4D when a one-time payment is made.
- Ongoing payments are subject to the normal filing requirements. In the example above, a fixed rate MOP based on the imputed earning capacity must also be filed in addition to the WCB-3A.

1. REVISION DATE:	**DISCONTINUANCE OF COMPENSATION**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PART(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

Your weekly compensation benefits are being discontinued.

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. REASON FOR DISCONTINUANCE (CHOOSE ONE):

- ☐ RETURNED TO WORK FOR SAME EMPLOYER REGULAR / FULL DUTY MEDICAL RELEASE (RULES CH. 8, §11(2))
- ☐ RETURNED TO WORK FOR SAME EMPLOYER EARNING AT / ABOVE AVERAGE WEEKLY WAGE (§205(9)(A))
- ☐ AGREEMENT OF THE PARTIES / BOARD DECISION (RULES, CH. 8 §12)
- ☐ LUMP SUM SETTLEMENT
- ☐ NOC FILED WITHIN 45 DAYS PURSUANT TO §205(2)(C)
- ☐ OTHER (EXPLAIN):_____

21. PERIOD OF INCAPACITY FROM DATE: THROUGH DATE:	22. WEEKLY NET AMOUNT FROM MEMORANDUM OF PAYMENT OR MOST RECENT MODIFICATION: $
23. TOTAL WEEKLY COMPENSATION PAID FOR THE PERIOD OF INCAPACITY IN BOX 21: $	24. DATE OF FINAL PAYMENT:

COMMENTS:

25. PREPARER'S FULL NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	26. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	27. DATE SENT TO WCB: WCB USE ONLY:

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-4D (Effective 6-1-2026)

WCB-4D Discontinuance of Compensation:

Due Date - Within 14 days after benefits are discontinued in accordance with one of the following:

- Returned to Work for Same Employer Regular/Full Duty Medical Release (Rules Ch. 8, §11(2))
- Returned to Work for Same Employer at/above Average Weekly Wage (§205(9)(A))
- Agreement of the parties/Board Decision (Rules Ch. 8 §12)
- Lump Sum Settlement
- NOC filed within 45 days pursuant to §205(2)(C)
- Other (rare!)

Box 21 - Period of incapacity

- "From" date must match the Date of Incapacity of the applicable MOP, otherwise it will be flagged as an issue.
- "Through" date should be up to and including the last day paid.

Box 22 – Weekly Net Amount - Must be the same as the weekly net amount from the MOP or most recent modification, otherwise it will be flagged as an issue.

Box 23 - Amount paid - Total amount paid for this period of incapacity. Do not include interest, penalties, amounts paid by the employer, or amounts paid to the "lead" carrier in apportionment cases. Do not reduce by any recoveries, including deductibles.

Box 24 - Date of final payment - the date the final benefit payment is mailed or electronically disbursed.

General

- There must be an actual return to work with the employer of injury to discontinue with a WCB-4D. See change to Rule Chapter 8 Section11(2)(C) regarding what is considered a return to work effective 9/1/18.
- A WCB-4D cannot be used to discontinue benefits when the employee returns to work for a new employer, is terminated, or retires!

1. REVISION DATE):	**MODIFICATION OF COMPENSATION**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

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

Your workers' compensation weekly compensation payments have been modified.

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. Reasons for Modification (check all that apply):

☐ Adjusted Wage/Rate (Rules Ch.1, §5(2)(C))	$	☐ Increased Earnings Same ER (§205(9)(A))	$
☐ Agreement/Board Decision (Rules Ch.8, §12)	$	☐ Max Rate Increase (§211)	$
☐ Apportionment (§354)	$	☐ Paid Time Off (§221(3)(A)(2))	$
☐ Change in Benefit Type		☐ RTW Same ER, Modified Duty (§205(9)(A))	$
☐ Change in Payment Type	$	☐ Social Security Retirement (§221(3)(A)(1))	$
☐ Cost of Living Adjustment	$	☐ Third Party Liability (§107)	$
☐ Decreased Earnings Same ER (§205(9)(A))	$	☐ Unemployment Compensation (§220)	$
☐ Disability Insurance (§221(3)(A)(2)-(3))	$	☐ Wage Continuation Plan (§221(3)(A)(2))	$
☐ Employer Funded Pension (§221(3)(A)(5))	$	☐ Other (Explain):	$
☐ Fringe Benefits (§102(4)(H))	$	☐ Other (Explain):	$

21. Payment Type:

☐ Weekly Compensation

☐ Specific Loss Body Part(s): Weeks:

☐ Salary Continuation (ER paying at/above AWW; insurer not paying any benefits at this time)

☐ Other (Explain):

22. Benefit type as of Effective Date:	23. Old Weekly Net Amount:	24. New Weekly Net Amount:	25. Effective Date of Modification:
☐ Total Incapacity (§212) ☐ Partial Incapacity (§213) ☐ Fatal (§215/§355(14)(F))	☐ Fixed $ ☐ Varying	☐ Fixed* $ *Salary Continuation amount or rate minus offsets, if any ☐ Varying	

Comments:

26. PREPARER'S FULL NAME (REQUIRED):	27. TELEPHONE NUMBER (REQUIRED):	28. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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-4M (Effective 6-1-2026)

WCB-4M Modification of Compensation:

Due Date - Within 14 days after benefits are modified in accordance with one or more of the following:

- Adjusted Wage/Rate - The employer/insurer may adjust the average weekly wage one time using form WCB-4 within 90 days after making the first lost time payment on a claim to correct an error or miscalculation.
- Agreement of the Parties/Board Decision
- Change in Benefit Type (total, partial, fatal)
- Change in Payment Type (weekly compensation, specific loss, salary continuation, other)
- Cost of Living Adjustment
- Fringe Benefits
- Increased/Decreased Earnings
- Max Rate Increase
- Coordination of Benefits
- Return to Work

Box 20 – Reasons for Modification - Check all the reasons that apply. If the Claims Management Unit cannot determine if the modification is valid, the form will be flagged as an issue.

Box 23 - Old Weekly Net Amount - Rate prior to modification. Amount must match the MOP or most recent modification, otherwise it will be flagged as an issue.

Box 24 - New Weekly Net Amount - Rate following modification.

Box 25 - Effective date - Date modification became effective, not the date the check was issued.

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

CONSENT BETWEEN EMPLOYER AND EMPLOYEE

1. REVISION DATE: ____/____/____ MM DD YYYY				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:			

20. TERMS OF CONSENT:			
20A. DATE OF INCAPACITY:	20B. AVERAGE WEEKLY WAGE:	20C. CURRENT WEEKLY COMPENSATION RATE: TOTAL ☐ PARTIAL ☐	20D. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): YES ☐ NO ☐
20E. NEW COMPENSATION RATE:	20F. EFFECTIVE DATE OF REDUCTION:	20G. EFFECTIVE DATE OF DISCONTINUANCE:	20H. AMOUNT PAID:

NOTICE TO EMPLOYEE (Please read and initial)

21. 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

22. WE AGREE TO THE TERMS LISTED IN BOX 20 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
442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	658 MAIN STREET SUITE 1 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

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. 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. 9/1/20, rev. 1/28/2026)

WCB-4A Consent Between Employer and Employee (CEE):

Due Date – Form is optional. No specific due date for the form itself, but payment is due within 10 calendar days after the agreement is effective (date of last signature).

Board Rules Chapter 8 § 18. govern the use of the WCB-4A:

1. 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) may be used when the parties agree to discontinue or reduce benefits during the 21-day period following the filing of a Certificate of Discontinuance or Reduction of Compensation (WCB-8). The Consent Between Employer and Employee (WCB-4A) cannot be used to reduce or discontinue benefits on a date that is subsequent to the date the parties sign the WCB-4A.

2. The WCB-4A shall be signed by the employee or a representative of the employee, and a representative of the insurer.

3. 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.

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

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

6. The WCB-4A shall be distributed as follows: (1) Workers' Compensation Board; (2) Employee; (3) Insurer; (4) Employer.

7. 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.

Board Rules Chapter 8 § 18. continued:

8. 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 § 205(9)(B)(2).

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

10. 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.

General

- Download the form from the Board's website to use the electronic signature feature.

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

1. REVISION DATE:		2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	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

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 must be on form WCB-121 and mailed to:

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

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

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

DISCONTINUANCE

21. PERIOD OF INCAPACITY FROM DATE: THROUGH DATE:		22. WEEKLY NET AMOUNT FROM MEMORANDUM OF PAYMENT OR MOST RECENT MODIFICATION: $
23. EFFECTIVE DATE OF DISCONTINUANCE:	24. COMPENSATION PAID TO DATE OF CERTIFICATE: $	25. COMPENSATION TO BE PAID FOR 21 DAY PERIOD: $

REDUCTION

26. OLD WEEKLY NET AMOUNT: ☐ FIXED $ ☐ VARYING	27. NEW WEEKLY NET AMOUNT: ☐ FIXED $ ☐ VARYING	28. EFFECTIVE DATE OF REDUCTION:

PREPARER

29. TYPE OR PRINT PREPARER NAME (REQUIRED):	30. TELEPHONE NUMBER (REQUIRED):	31. DATE MAILED VIA CERTIFIED MAIL:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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 (Effective 6-1-2026)

WCB-8 Certificate of Discontinuance or Reduction of Compensation (21-Day):

Due Date – Send by certified mail to the employee and to the board, together with any information on which the employer, insurer or group self-insurer relied to support the discontinuance or reduction. The employer may discontinue or reduce benefits no earlier than 21 days from the date the certificate was mailed to the employee.

Box 20 - Reason for discontinuance - Enter a brief description of the reason for the discontinuance or reduction and attach supporting documentation. "See attached" is not a reason and will be flagged as an issue.

Box 21 - Period of incapacity

- "From" date must match the Date of Incapacity of the applicable MOP, otherwise it will be flagged as an issue.
- "Through" date should be up to and including the last day paid.

Box 22- Weekly Net Amount - Amount must match the MOP or most recent modification, otherwise it will be flagged as an issue.

Box 23 – Effective Date of Discontinuance – Must be no earlier than 21 days from the date the form was mailed via certified mail (Box 31).

Box 24- Compensation Paid to Date of Certificate - Total amount paid (or due) to the date the form is mailed for the period of incapacity. Do not include interest, penalties, amounts paid by the employer, or amounts paid to the "lead" carrier in apportionment cases. Do not reduce by any recoveries, including deductibles.

Box 25 – Compensation To Be Paid for the 21-day period - Total amount to be paid for the 21-day notice period. This should be a dollar amount. Boxes 24 and 25 should equal the total weekly compensation paid (or due) for the period listed in Box 21.

Box 26 - Old weekly Net Amount - Rate prior to reduction. Amount must match the MOP or most recent modification, otherwise it will be flagged as an issue.

Box 26 - New Weekly Net Amount - Rate following reduction.

Box 27 - Effective Date of Reduction - Must be no earlier than 21 days from the date the form was mailed via certified mail to the employee (Box 31).

General

- Use if benefits are discontinued or reduced for any reason other than those which allow the filing of a WCB-4D unless indemnity is being paid pursuant to an order or award, or compensation scheme.
- Complete the Discontinuance or Reduction section, but not both.
- Send certified mail to the employee and to the board, together with any information on which the employer, insurer or group self-insurer relied to support the discontinuance or reduction. Be sure to get post-marked receipts from the post office upon mailing.
- Do not count the day form is mailed in calculating the 21 days. For example, if mailed May 5 (Box 31), add 21 days and use effective date of May 26 in Box 23 (Discontinuance) or 28 (Reduction.
- Best practice is to include a cover letter with the WCB-8 which includes both certified mail numbers.
- Use form 231-A to take an offset for earnings when the employee returns to work for a new employer.
    - When benefits are discontinued or reduced pursuant to § 205(9)(B)(1): 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. Failure to file the documentation with the amended form will be flagged as an issue.
    - When benefits are discontinued or reduced pursuant to § 205(9)(B)(2): 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 actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4 showing the adjustment that was made. Failure to file the documentation with form WCB-4 will be flagged as an issue.

1. REVISION DATE: ____/____/____ MM DD YYYY	**NOTICE OF CONTROVERSY** **THIS IS A DENIAL OF YOUR BENEFITS**	2. WCB FILE NUMBER (REQUIRED): DN5

EMPLOYEE

3. EMPLOYEE LAST NAME: DN43	4. FIRST NAME: DN44	5. MI.: DN45	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-DN42	
7. EMPLOYEE MAILING ADDRESS: DN46	8. CITY: DN48	9.STATE: DN49	10. ZIP: DN50	11. PHONE NUMBER: DN51
12. DATE OF INJURY: ____/____/____ DN31 MM DD YYYY	13. SPECIFIC INJURY OR ILLNESS: DN35		14. BODY PARTS (S) AFFECTED: DN36	

EMPLOYER/INSURER

15. INSURER FILE NUMBER: DN15	16. EMPLOYER NAME: DN18	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER: DN168, 165, 170, 167, AND 159
18. INSURER NAME: DN188	19.INSURER MAILING ADDRESS AND PHONE NUMBER: DN10, 12, 13, 14, AND 137	

NOTICE TO EMPLOYEE

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

20a. **FULL DENIAL REASON**

DN198

FULL DENIAL EFFECTIVE DATE: DN199

*NOTE: Reasons identified in boxes 20a or 20b will not preclude a party from raising additional issues at a later date.

20b. **PARTIAL DENIAL REASON**

DN294

21a.

DATE OF INITIAL INCAPACITY: DN56

CURRENT DATE OF INCAPACITY: DN144

21b.

DATE EMPLOYER NOTIFIED: DN281

22. COMMENTS:

DN197

23. ANY EMPLOYER OR INSURER THAT FAILS TO FILE A NOTICE OF CONTROVERSY IN A TIMELY FASHION AS REQUIRED BY 39-A M.R.S. § 205 (2) MAY BE OBLIGATED TO PAY PENALTIES AS REQUIRED BY THE WORKERS' COMPENSATION ACT AND RULES. QUESTIONS PERTAINING TO THIS OBLIGATION MAY BE DIRECTED TO A CLAIMS RESOLUTION SPECIALIST AT ONE OF THE REGIONAL OFFICES LISTED BELOW.

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
442 CIVIC CTR DR, STE 225 MAIL: 156 SHS	396 GRIFFIN RD, STE 105	658 MAIN ST, STE 1	36 MOLLISON WAY	56 NORTHPORT DR, STE 201
AUGUSTA, ME 04333-0156	BANGOR, ME 04401-5638	CARIBOU, ME 04736	LEWISTON, ME 04240-7777	PORTLAND, ME 04103
(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

24. TYPE OR PRINT NAME (REQUIRED): DN140 E-MAIL ADDRESS (REQUIRED): DN138	25. TELEPHONE NUMBER (REQUIRED): DN137 TOLL-FREE NUMBER: N/A	26. DATE SENT TO WCB: DN100 27. DATE RCVD AT WCB (WCB USE ONLY):

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 (effective 9/1/2020, revised 4/1/26)

WCB-9 Notice of Controversy (NOC):

Due Date - File electronically using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format within 14 days of notice/knowledge of a claim for incapacity or death benefits. For denial of medical benefits only, file within 30 days of notice/knowledge of claim for medical benefits.

Box 21a.

- Date of initial incapacity - first day qualifying as a day of disability.
- Current date of incapacity - first qualifying day of disability in the current period of disability being denied. If the same as above, leave blank.

Box 21b. - Date Employer Notified – is for the current date of incapacity.

Box 22 - Comments - Use for additional information, explanations, or clarifications. If disability has been intermittent or sporadic, it should be noted here.

General

- Original NOCs must be via EDI, paper filings will be discarded, and notice of this action may not be given.
- NOC revisions cannot be filed via EDI. Must be filed via email, fax, mail or in-hand delivery.
- A NOC cannot change the injury code type for the claim. To do this, a FROI-02 must be filed via EDI.
- A WCB-2 and WCB-2B must be filed within 30 days of the employer's notice or knowledge of the initial incapacity.
- If a NOC is filed on a medical only claim and it later becomes a lost time claim, a new NOC must be filed to dispute indemnity.
- If a lost time NOC is filed, it can NOT be revised to medical only, even if there is no lost time. The WCB-2 and WCB-2B must be filed.
- If filed late, benefits must be paid, with credit for earnings and other statutory offsets, from the date the claim was made through the date the NOC is filed (and accepted), and payment made. A mandatory MOP must be filed.
- The copy to the employee must be materially the same as the one filed EDI with the Board (pdf file is sent with the AKC report).

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

LUMP SUM SETTLEMENT

1. REVISION DATE: _____/_____/_____ (MM DD YYYY)

2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE NAME:	4. SOCIAL SECURITY # (last 4 digits): XXX-XX-	5. EMPLOYEE ADDRESS:
6. DATE OF INJURY:	7. SPECIFIC INJURY OR ILLNESS:	8. BODY PARTS (S) AFFECTED:

EMPLOYER/INSURER

9. EMPLOYER NAME:	10. EMPLOYER MAILING ADDRESS:
11. INSURER NAME:	12. INSURER FILE NUMBER:

13. TYPE OF SETTLEMENT:

☐ STRUCTURED SETTLEMENT
PRESENT VALUE OF SETTLEMENT $_____

☐ LUMP SUM SETTLEMENT
TOTAL VALUE OF SETTLEMENT $_____

14. COMMENTS:

RELEASES

15. **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 ADMINISTRATIVE LAW JUDGE, 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) _____ (TYPE OR PRINT)

_____ (EMPLOYEE REPRESENTATIVE SIGNATURE) _____ (DATE) _____ (TYPE OR PRINT)

16. **EMPLOYER:**

THE EMPLOYER WAS NOTIFIED OF SETTLEMENT: ☐ YES ☐ NO OBJECTION: ☐ YES ☐ NO

THE EMPLOYER CONSENTS TO THE SETTLEMENT: _____ (EMPLOYER REPRESENTATIVE SIGNATURE) _____ (DATE) _____ (TYPE OR PRINT)

17. **INSURER:** THE INSURER CONSENTS TO THE SETTLEMENT:

_____ (INSURER REPRESENTATIVE SIGNATURE) _____ (DATE) _____ (TYPE OR PRINT)

DECISION

18. 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.
EXPECTED FUTURE MEDICAL COSTS $ _____.

_____ (ADMINISTRATIVE LAW JUDGE SIGNATURE) _____ (DATE)

FOR INTERNAL 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-10 (Effective 6-1-2026)

WCB-10 Lump Sum Settlement (LSS):

Due Date - No specific due date for the form itself, but payment is due within 10 days after the receipt of notice of an approved agreement for payment of compensation or within 10 days after any order or decision of the board awarding compensation.

Box 13

- Structured Settlement – a structured settlement is when any part of the settlement monies (indemnity and/or medical) is paid out in yearly installments over a number of years. For structured settlements, enter the present value of the settlement.

  Example:
  - Cash payment to employee: $40,000
  - Annuity payments of $2,500/year payable for the lifetime of the employee (cost of the annuity = $1,000)
  - Cash payment to establish/seed the MSA account: $1,000
  - Annuity payments of $500 over 27 years to fund the MSA (cost of the annuity = $100)
  - Cash payment to MSA administrator: $800
  - Cash payment to employee/dependent's attorney: $5,000
  - Expected future medical costs: $13,500

    Present Value of Settlement: $47,100

- Lump Sum Settlement – enter the total value of the settlement.

  Example:
  - Cash payment to employee: $40,000
  - Cash payment to establish/seed the MSA account: $15,000
  - Cash payment to MSA administrator: $800
  - Cash payment to employee/dependent's attorney: $5,000
  - Expected future medical costs: $15,000

    Total Value of Settlement: $60,000

1.REVISION DATE:	**STATEMENT OF COMPENSATION PAID**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	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

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. REASON FOR REPORT (CHOOSE ONE):

☐ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)

☐ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

PAYMENT SUMMARY

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

MEDICAL TREATMENT	$	**DEATH BENEFIT/FUNERAL EXPENSE** (NOT TO EXCEED $7,000)	$
WEEKLY COMPENSATION	$	**EMPLOYEE-RELATED LEGAL EXPENSE**	$
PERMANENT IMPAIRMENT (PRE1993 CLAIMS ONLY)	$	**EMPLOYER-RELATED LEGAL EXPENSE**	$
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.)		$

COMMENTS:

22. PREPARER'S FULL NAME (REQUIRED):	23. TELEPHONE NUMBER (REQUIRED):	24. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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WCB-11A (Effective 6-1-2026)

1. REVISION DATE:	**STATEMENT OF COMPENSATION PAID**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. 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

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

20. TYPE: ☐ **INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)** ☐ **FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)**

21. LIST CUMULATIVE TOTALS:

MEDICAL TREATMENT (TREATMENT DOES NOT INCLUDE EXPENSES RELATED TO MANAGED CARE SERVICES SUCH AS UTILIZATION REVIEW, CASE MANAGEMENT, AND BILL REVIEW, OR TO EXAMS PERFORMED PURSUANT TO §§ 207 AND 312.)	$	**DEATH BENEFIT/FUNERAL EXPENSE** (NOT TO EXCEED $7,000)	$
WEEKLY COMPENSATION (WHEN FILING THIS FORM AS A FINAL, THIS AMOUNT MUST MATCH THE SUM OF THE AMOUNT PAID ON ALL PAYMENT FORMS)	$	**EMPLOYEE-RELATED LEGAL EXPENSE**	$
		EMPLOYER-RELATED LEGAL EXPENSE	$
PERMANENT IMPAIRMENT (PRE-1993 CLAIMS ONLY)	$	**INTEREST AND OTHER PAYMENTS** (OTHER PAYMENTS INCLUDE BUT ARE NOT LIMITED TO: EXPERT WITNESS FEES, COURT REPORTER FEES, PRIVATE INVESTIGATOR FEES, MEDICAL AND OTHER TRAVEL COSTS, COSTS RELATED TO MANAGED CARE SERVICES SUCH AS UTILIZATION REVIEW, CASE MANAGEMENT, AND BILL REVIEW, AND EXAMS PERFORMED PURSUANT TO §§ 207 AND 312)	$
EMPLOYMENT REHABILITATION	$		
LUMP SUM SETTLEMENT (THIS AMOUNT MUST MATCH THE APPROVED AMOUNT ON FORM WCB-10)	$		

TOTAL AMOUNT PAID (DO NOT INCLUDE ANY PENALTY AMOUNTS, AMOUNTS PAID TO THE "LEAD" CARRIER ON APPORTIONMENT CASES, OR AMOUNTS PAID BY THE EMPLOYER. DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES.) $

COMMENTS:

22. PREPARER'S FULL NAME (REQUIRED):	23. TELEPHONE NUMBER (REQUIRED):	24. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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WCB-11B (Effective 6-1-2026)

WCB-11 Statement of Compensation Paid (SOC):

Due Dates

- Initial report due within 195 days of date of injury.
- Annual - within 15 days of each anniversary date of the injury if payments of any type were made since the previous SOC.
- Final - no further payments are anticipated.
- Not required if no indemnity benefits were ever paid.

Box 20 - Reason for report - Indicate interim (ongoing payments of any kind) or final (no further payments anticipated).

Box 21 - Cumulative totals

- Medical Treatment - Does not include expenses related to managed care services such as utilization review, case management, and bill review, or to exams performed pursuant to §207 and §312.
- Weekly Compensation - Sum of all payments pursuant to § 212, § 213, and § 215. Do not include amounts paid by the employer or amounts paid to the "lead" carrier on apportionment cases. When filing this form as a final, this amount must match the sum of the Amount Paid on all payment forms, otherwise the form will be flagged as an issue.
- Permanent Impairment - For injuries prior to 1993 only. Not the same as specific loss.
- Employment Rehabilitation - Employment rehabilitation expenses paid.
- Lump Sum Settlement - This amount must match the approved amount on form WCB-10.
- Death Benefit/Funeral Expense - Payments pursuant to § 216. Cannot exceed $7,000.00.
- Legal Expense - the sum of all legal expenses paid for the claim - separated into employee-related and employer-related expenses.
- Interest and Other Payments - Payments not otherwise reported for this claim, such as expert witness fees, court reporter fees, private investigator fees, medical and other travel costs, costs related to managed care services such as utilization review, case management, and bill review, and exams pursuant to §207 and §312.
- Do not include any penalty amounts, nor reduce any totals by the amount of any recoveries, including deductibles.

General

- Revise the form when the amounts were incorrect as of the date of the report.
- When payments are made after the previous filing, this is a new filing, not a revision.
- When amounts decrease, the comment box must indicate the reason, otherwise the form will be flagged as an issue.