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.