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

SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT

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:		

BOXES 20-24 TO BE COMPLETED BY EMPLOYEE

20. **FEDERAL TAX FILING STATUS**

- ☐ **SINGLE**
- ☐ **MARRIED/JOINT**
- ☐ **SINGLE/HEAD OF HOUSEHOLD**
- ☐ **MARRIED/SEPARATE**

21. **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.			

22. TYPE OR PRINT PREPARER NAME AND TITLE (REQUIRED): E-MAIL ADDRESS (REQUIRED):	23. TELEPHONE NUMBER (REQUIRED):	24. DATE MAILED: ____/____/____ MM DD YYYY

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.