

MEMORANDUM OF PAYMENT

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:	

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) ____/____/____ THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) ____/____/____
MM DD YYYY MM DD YYYY

21. TYPE OF PAYMENT: A. <input type="checkbox"/> WEEKLY COMPENSATION B. <input type="checkbox"/> SPECIFIC LOSS: _____ WEEKS C. <input type="checkbox"/> SALARY CONTINUATION D. <input type="checkbox"/> OTHER (EXPLAIN): _____	22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET: ____/____/____ MM DD YYYY	23. DATE OF INCAPACITY: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED OF INCAPACITY: ____/____/____ MM DD YYYY	24. DATE CHECK MAILED: ____/____/____ MM DD YYYY	25. AVERAGE WEEKLY WAGE: \$ _____
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26. WEEKLY CHECK AMOUNT (NET): \$ _____ (IF VARYING RATES ARE BEING PAID, ENTER THE WORD "VARYING") BENEFIT TYPE: A. <input type="checkbox"/> TOTAL INCAPACITY (§212) B. <input type="checkbox"/> PARTIAL INCAPACITY (§213) C. <input type="checkbox"/> FATAL (§215/§355 (14) (F))	27. WEEKLY CHECK REDUCED FOR: A. <input type="checkbox"/> 3 rd PARTY LIABILITY (§107) \$ _____ B. <input type="checkbox"/> EARNINGS ((§213(1)) \$ _____ C. <input type="checkbox"/> UNEMPLOYMENT COMPENSATION (§220) \$ _____ D. <input type="checkbox"/> SOCIAL SECURITY RETIREMENT (§221(3)(A)(1)) \$ _____ E. <input type="checkbox"/> PAID TIME OFF (§221(3)(A)(2)) \$ _____ F. <input type="checkbox"/> WAGE CONTINUATION PLAN (§221(3)(A)(2)) \$ _____ G. <input type="checkbox"/> DISABILITY INSURANCE (§221(3)(A)(3)) \$ _____ H. <input type="checkbox"/> EMPLOYER FUNDED PENSION (§ 221(3)(A)(5)) \$ _____ I. <input type="checkbox"/> APPORTIONMENT (§ 354) \$ _____ J. <input type="checkbox"/> OTHER: _____ \$ _____ K. <input type="checkbox"/> NOT APPLICABLE
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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 442 CIVIC CTR. DRIVE, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	BANGOR 396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	CARIBOU ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	LEWISTON 36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	PORTLAND 1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858
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29. PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	30. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	31. DATE MAILED: ____/____/____ MM DD YYYY
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