

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

1. REVISION DATE: _____
MM / DD / YYYY

2. WCB FILE NUMBER
(REQUIRED): _____

MEMORANDUM OF PAYMENT

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 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

20. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS FORM UPON MAKING THE FIRST PAYMENT OF COMPENSATION FOR INCAPACITY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

- YOUR CLAIM IS ACCEPTED
 THIS IS A VOLUNTARY PAYMENT (PAYMENT WITHOUT PREJUDICE)
 THIS IS A MANDATORY PAYMENT PURSUANT TO RULE 1.1 AND §205(2) AMOUNT PAID \$ _____

PAYMENT FROM (DATE CLAIM MADE) MM / DD / YYYY PAYMENT THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) MM / DD / YYYY

21. PAYMENT TYPE: <input type="checkbox"/> WEEKLY COMPENSATION <input type="checkbox"/> SPECIFIC LOSS: _____ WEEKS <input type="checkbox"/> SALARY CONTINUATION <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
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25. AVERAGE WEEKLY WAGE: \$ _____	26. BENEFIT TYPE: <input type="checkbox"/> TOTAL INCAPACITY (§212) <input type="checkbox"/> PARTIAL INCAPACITY (§213) <input type="checkbox"/> FATAL (§215/§355 (14) (F))	27. NET CHECK AMOUNT (AFTER OFFSETS): <input type="checkbox"/> FIXED \$ _____ THIS AMOUNT IS EQUAL TO THE EMPLOYEE'S WEEKLY COMPENSATION RATE MINUS OFFSETS REPORTED IN BOX 27A. <input type="checkbox"/> VARYING
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27A. NET CHECK AMOUNT REDUCED FOR (OFFSETS):			
<input type="checkbox"/> APPORTIONMENT (§354) \$ _____	<input type="checkbox"/> SOCIAL SECURITY RETIREMENT (§221(3)(A)(1)) \$ _____	<input type="checkbox"/> DISABILITY INSURANCE (§§221(3)(A)(2)-(3)) \$ _____	<input type="checkbox"/> THIRD PARTY LIABILITY (§107) \$ _____
<input type="checkbox"/> EARNINGS FROM SAME EMPLOYER \$ _____	<input type="checkbox"/> UNEMPLOYMENT COMPENSATION (§220) \$ _____	<input type="checkbox"/> EMPLOYER FUNDED PENSION (§ 221(3)(A)(5)) \$ _____	<input type="checkbox"/> WAGE CONTINUATION PLAN (§221(3)(A)(2)) \$ _____
<input type="checkbox"/> PAID TIME OFF (§§221(3)(A)(2)) \$ _____	<input type="checkbox"/> OTHER: _____	<input type="checkbox"/>	<input type="checkbox"/>

27B. IF THIS IS AN APPORTIONMENT CLAIM, PLEASE COMPLETE THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: _____

OTHER INSURER(S) INVOLVED: _____

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 658 MAIN STREET SUITE 1 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 56 NORTHPORT DR, STE 201 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858
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29. PREPARER'S FULL NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	30. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	31. DATE SENT TO WCB: MM / DD / YYYY
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