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:

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.