

MODIFICATION OF COMPENSATION

1. REVISION DATE: MM / DD / YYYY		STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027			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:				

INCREASE	DECREASE
<p>20. WEEKLY CHECK INCREASED FOR:</p> <ul style="list-style-type: none"> <input type="checkbox"/> DECREASED EARNINGS WITH SAME EMPLOYER <input type="checkbox"/> FRINGE BENEFITS <input type="checkbox"/> BOARD DECISION <input type="checkbox"/> MAX RATE INCREASE <input type="checkbox"/> COST OF LIVING ADJUSTMENT <input type="checkbox"/> 3rd PARTY LIABILITY (§107) <input type="checkbox"/> EARNINGS ((§213(1)) <input type="checkbox"/> UNEMPLOYMENT COMPENSATION (§220) <input type="checkbox"/> SOCIAL SECURITY RETIREMENT (§221(3)(A)(1)) <input type="checkbox"/> PAID TIME OFF (§221(3)(A)(2)) <input type="checkbox"/> WAGE CONTINUATION PLAN (§221(3)(A)(2)) <input type="checkbox"/> DISABILITY INSURANCE (§221(3)(A)(3)) <input type="checkbox"/> EMPLOYER FUNDED PENSION (§ 221(3)(A)(5)) <input type="checkbox"/> APPORTIONMENT (§ 354) <input type="checkbox"/> OTHER (EXPLAIN): _____ 	<p>21. WEEKLY CHECK DECREASED FOR:</p> <ul style="list-style-type: none"> <input type="checkbox"/> INCREASED EARNINGS WITH SAME EMPLOYER <input type="checkbox"/> FRINGE BENEFITS <input type="checkbox"/> BOARD DECISION <input type="checkbox"/> RETURNED TO WORK FOR SAME EMPLOYER, MODIFIED WORK/DUTY <input type="checkbox"/> 3rd PARTY LIABILITY (§107) <input type="checkbox"/> EARNINGS ((§213(1)) <input type="checkbox"/> UNEMPLOYMENT COMPENSATION (§220) <input type="checkbox"/> SOCIAL SECURITY RETIREMENT (§221(3)(A)(1)) <input type="checkbox"/> PAID TIME OFF (§221(3)(A)(2)) <input type="checkbox"/> WAGE CONTINUATION PLAN (§221(3)(A)(2)) <input type="checkbox"/> DISABILITY INSURANCE (§221(3)(A)(3)) <input type="checkbox"/> EMPLOYER FUNDED PENSION (§ 221(3)(A)(5)) <input type="checkbox"/> APPORTIONMENT (§ 354) <input type="checkbox"/> OTHER (EXPLAIN): _____

22. OLD COMPENSATION RATE:		23. NEW COMPENSATION RATE:	24. EFFECTIVE DATE OF MODIFICATION:
25. BENEFIT TYPE:		26. COMMENTS:	
<p>A. <input type="checkbox"/> TOTAL (§212)</p> <p>B. <input type="checkbox"/> PARTIAL (§213)</p> <p>C. <input type="checkbox"/> FATAL (§215/§355 (14) (F))</p>			

ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

AUGUSTA
442 CIVIC CTR DR, 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

27. PREPARER NAME (REQUIRED):		28. TELEPHONE NUMBER (REQUIRED):	29. DATE MAILED: MM / DD / YYYY
E-MAIL ADDRESS (REQUIRED):		TOLL-FREE NUMBER:	