

# MODIFICATION OF COMPENSATION

1. REVISION DATE:  MM / DD / YYYY		<b>STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027</b>			2. WCB FILE NUMBER (if known):	
<b>EMPLOYEE</b>						
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:	
<b>EMPLOYER/INSURER</b>						
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
20. WEEKLY CHECK INCREASED FOR:  <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"/> 3 <sup>rd</sup> 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): _____	21. WEEKLY CHECK DECREASED FOR:  <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"/> 3 <sup>rd</sup> 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: A. <input type="checkbox"/> TOTAL (§212) B. <input type="checkbox"/> PARTIAL (§213) C. <input type="checkbox"/> FATAL (§215/§355 (14) (F))		26. COMMENTS:			

**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**  
106 HOGAN RD  
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):  E-MAIL ADDRESS (REQUIRED):		28. TELEPHONE NUMBER (REQUIRED):  TOLL-FREE NUMBER:		29. DATE MAILED:  MM / DD / YYYY	
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