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

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**MODIFICATION OF COMPENSATION**	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. 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 THE MODIFICATION OF YOUR WEEKLY COMPENSATION PAYMENTS. YOUR WEEKLY COMPENSATION PAYMENTS HAVE BEEN MODIFIED FOR THE FOLLOWING REASON(S):

☐ AGREEMENT OF THE PARTIES/BOARD DECISION (RULES CH.8, §12)	$_____	☐ INCREASED EARNINGS WITH SAME EMPLOYER (§205(9)(A))	$_____
☐ ADJUSTED WAGE/RATE (RULES CH.1, §5(2)(C))	$_____	☐ MAX RATE INCREASE (§211)	$_____
☐ APPORTIONMENT (§354)	$_____	☐ PAID TIME OFF (§221(3)(A)(2))	$_____
☒ CHANGE IN PAYMENT TYPE	$_____	☐ RTW WITH SAME EMPLOYER, MODIFIED DUTY (§205(9)(A))	$_____
☐ COST OF LIVING ADJUSTMENT	$_____	☐ SOCIAL SECURITY RETIREMENT (§221(3)(A)(1))	$_____
☐ DECREASED EARNINGS WITH SAME EMPLOYER (§205(9)(A))	$_____	☐ THIRD PARTY LIABILITY (§107)	$_____
☐ DISABILITY INSURANCE (§221(3)(A)(2)-(3))	$_____	☒ UNEMPLOYMENT COMPENSATION (§220)	$_____
☐ EMPLOYER FUNDED PENSION (§221(3)(A)(5))	$_____	☐ WAGE CONTINUATION PLAN (§221(3)(A)(2))	$_____
☐ FRINGE BENEFITS (§102(4)(H))	$_____	☐ OTHER (EXPLAIN): _____	$_____

21. PAYMENT TYPE:	22. BENEFIT TYPE:
☐ WEEKLY COMPENSATION	☐ TOTAL (§212)
☒ SPECIFIC LOSS _____ WEEKS	☐ PARTIAL (§213)
☒ SALARY CONTINUATION	☐ FATAL (§215/§355(14)(F))
☐ OTHER (EXPLAIN):_____	

23. OLD WEEKLY CHECK AMOUNT:	24. NEW WEEKLY CHECK AMOUNT:	25. EFFECTIVE DATE OF MODIFICATION:
☐ FIXED $ _____	☐ FIXED $ _____	_____/_____/_____ MM DD YYYY
☒ VARYING	☐ VARYING	

26. COMMENTS:

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
442 CIVIC CTR DR, STE 225	396 GRIFFIN RD, STE 105	658 MAIN STREET	36 MOLLISON WAY	56 NORTHPORT DR, STE 201
156 STATE HOUSE STATION	BANGOR, ME	SUITE 1	LEWISTON, ME	PORTLAND, ME
AUGUSTA, ME 04333-0156	04401-5638	CARIBOU, ME 04736	04240-7777	04103
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855		1-800-400-6858

27. PREPARER'S FULL NAME (REQUIRED):	28. TELEPHONE NUMBER (REQUIRED):	29. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	_____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. 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.
WCB-4M (effective 04/01/2025)