CERTIFICATE AUTHORIZING
RELEASE OF BENEFIT INFORMATION
STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

PART I (COMPLETED BY EMPLOYER/INSURER)

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (last 4 digits):		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

PART II (COMPLETED BY EMPLOYEE)

I, _____, DATE OF BIRTH _____ AUTHORIZE THE EMPLOYER/INSURER TO OBTAIN WRITTEN INFORMATION INDICATING THE NATURE AND AMOUNT OF BENEFITS I RECEIVED OR AM RECEIVING FROM THE FOLLOWING:

☐ SOCIAL SECURITY ADMINISTRATION

☐ EMPLOYEE BENEFITS PLAN

_____
NAME OF EMPLOYEE BENEFIT PLAN

_____
ADDRESS- NUMBER AND STREET

_____
CITY, STATE, ZIP

I UNDERSTAND THAT THE EMPLOYER/INSURER IS ENTITLED TO RECEIVE THIS SOCIAL SECURITY OLD AGE INSURANCE OR EMPLOYEE BENEFIT PLAN INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5) AND THAT **MY FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT MY WORKERS' COMPENSATION INDEMNITY BENEFITS.** THIS CERTIFICATE OF RELEASE IS VALID FOR ONE YEAR FROM THE DATE OF MY SIGNATURE.

SIGNATURE: _____ DATE:_____

PART III (COMPLETED BY SOCIAL SECURITY ADMINISTRATION OR EMPLOYEE BENEFIT PLAN ADMINISTRATOR)

THE EMPLOYEE AUTHORIZES THE RELEASE OF BENEFIT INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5). PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE EMPLOYER/INSUER:

1. EFFECTIVE DATE OF ELIGIBILITY: _____
2. CURRENT GROSS MONTHLY AMOUNT: _____
3. PERCENTAGE OF EMPLOYEE BENEFIT PLAN PAID BY EMPLOYER (IF APPLICABLE): _____
4. IF BENEFITS FROM THIS EMPLOYEE BENEFIT PLAN ARE SUBJECT TO REDUCTION BASED ON RECEIPT OF WORKERS' COMPENSATION BENEFITS, PLEASE EXPLAIN:

5. COMMENTS:

6. BENEFIT INFORMATION SENT TO THE EMPOYER/INSURER ON: _____

SIGNATURE: _____ DATE:_____

PREPARER NAME (TYPE OR PRINT):_____ TELEPHONE NUMBER:_____

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-6 (eff. 1/1/13, revised 1/1/14)