

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

**CERTIFICATE AUTHORIZING
RELEASE OF BENEFIT INFORMATION**

1. REVISION DATE: _____
MM / DD / YYYY

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:			

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/INSURER:

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 EMPLOYER/INSURER ON: _____ DATE: _____

SIGNATURE: _____

DATE: _____

PREPARER NAME (TYPE OR PRINT): _____

TELEPHONE NUMBER: _____