# State of Maine

# Workers' Compensation Board

# FORMS TRAINING

# MINI-MANUAL

*The general mission of the Maine Workers' Compensation Board is to serve the employees and employers of the State fairly and expeditiously by ensuring compliance with the workers' compensation laws, ensuring the prompt delivery of benefits legally due, promoting the prevention of disputes, utilizing dispute resolution to reduce litigation and facilitating labor-management cooperation.*

Revised 4-22-25

## Disclaimer

This document was prepared as a supplement to the training and outreach efforts and programs of the Maine Workers' Compensation Board, and for use solely in those training programs. Its purpose is simply to address some of the more common misunderstandings, errors, and ambiguities encountered by employers, insurers, claims adjusters, administrators, and employees of the Board in the course of their duties. It addresses the more common forms and appendices.

This document is not in any way meant to replace or be a substitute for the Board's Forms Manual, nor is it in any way meant to be a source of legal advice or opinion.

The full Forms and Petitions Manual, as well as Maine WC Law, Rules, blank forms, WC Board newsletters, Compliance Reports, training modules, and other Board information may be found online at www.maine.gov/wcb.

My contact information is below. Please feel free to contact me with any comments, questions or other inquiries.

Amanda DiPietro
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Maine Workers' Compensation Board
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Amanda.DiPietro@maine.gov

| MAINE WORKERS' COMPENSATION BOARD FORMS REFERENCE GUIDE | | | | |
|---|---|---|---|---|
| **BOARD FORM** | | **STATUTES** | **RULES** | **FILING REQUIREMENTS** |
| WCB-1 | First Report of Injury | §303 | 1.7<br>3.1<br>3.4<br>8.13<br>8.16 | Filed electronically within 7 days notice/knowledge of incapacity. |
| WCB-2* | Wage Statement | §153(4)<br>§205(8)<br>§303 | 1.7 | Filed within 30 days notice/knowledge of a claim for compensation. |
| WCB-2B | Fringe Benefits Worksheet | §303 | 1.7<br>8.9 | Filed within 30 days notice/knowledge of a claim for compensation. |
| WCB-3* | Memorandum of Payment | §153(1)(B)<br>§205(7) | 1.1<br>1.7<br>8.12 | Filed within 14 days notice/knowledge of a claim for incapacity or death benefits. |
| WCB-4D* | Discontinuance of Compensation | §205(9)(A) | 1.7<br>8.11<br>8.12 | Filed within 14 days after benefits are discontinued pursuant to 39-A M.R.S.A. §205(9)(A). |
| WCB-4M* | Modification of Compensation | §205(9)(A) | 1.7<br>8.11<br>8.12 | Filed within 14 days after benefits are reduced pursuant to 39-A M.R.S.A. §205(9)(A). |
| WCB-4A | Consent Between Employer and Employee | | 8.18 | Filed when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification or discontinuance in ongoing weekly incapacity benefits. |
| WCB-8* | Certificate of Discontinuance or Reduction of Compensation | §205(9)(B)(1) | 1.7<br>8.15 | Filed via certified mail no later than 21 days prior to the effective date of the discontinuance or reduction of benefits. pursuant to 39-A M.R.S.A. §205(9)(B)(1). |
| WCB-9 | Notice of Controversy | §313(1) | 1.1<br>1.7<br>3.4<br>8.2<br>8.12 | Filed electronically within 14 days of claim for incapacity or death benefits. |
| WCB-11* | Statement of Compensation Paid | | 1.7<br>8.1<br>8.12 | Filed within 195 days from the date of injury when indemnity benefits are paid and annually on the anniversary date of the injury subsequent to that. Final report when no further benefits are anticipated. |

* Forms Revised Effective 4-1-25

# EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

## REASON FOR REPORT (check all that apply)

2a. • LOST TIME - ONE OR MORE DAYS

2b. WAS EMPLOYEE PAID FOR 1/2 DAY OR MORE ON DAY OF INJURY? • YES • NO

3. • LOST EARNINGS BUT NO LOST TIME

4. • MEDICAL/HEALTH CARE

5. • FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. • OCCUPATIONAL DISEASE

6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY

6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. • CORRECT PRIOR REPORT

7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY

7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY

## EMPLOYER

| 8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN): | 9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): | | 10. EMPLOYER NAME: | |
|---|---|---|---|---|
| 11. STREET/P.O. BOX MAILING ADDRESS: | 12. CITY: | 13. STATE: | 14. ZIP: | 15. TELEPHONE NUMBER: ( ) |
| 16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED: | 17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS: | 18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? • YES • NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED: | | |

(check one) INSURER THIRD PARTY ADMINISTRATOR (TPA) SELF-ADMINISTERED EMPLOYER

| 19. INSURANCE/TPA COMPANY NAME: | 20. POLICY NUMBER: | | 21. INSURER FILE NUMBER: | |
|---|---|---|---|---|
| 22. STREET/P.O. BOX MAILING ADDRESS: | 23. CITY: | 24. STATE: | 25. ZIP: | 26. TELEPHONE NUMBER: ( ) |

## EMPLOYEE

| 27. LAST NAME: | 28. FIRST NAME: | 29. MI: | 30. TELEPHONE NUMBER: ( ) | 31. SOCIAL SECURITY NUMBER: XXX-XX- | 32. GENDER: • MALE • FEMALE |
|---|---|---|---|---|---|
| 33. STREET/P.O. BOX MAILING ADDRESS: | 34. CITY: | | 35. STATE: | 36. ZIP: | 37. DATE OF BIRTH: ____/____/____ MM DD YYYY |
| 38. OCCUPATION/JOB TITLE: | 39. DATE OF HIRE: ____/____/____ MM DD YYYY | 40. WEEKLY WAGE AT TIME OF INJURY: $ | | 41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? • YES • NO IF YES, GIVE NAME AND ADDRESS: | |

## CLAIM INFORMATION

| 42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY<br>DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY | 43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY<br>DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY | 44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):<br>46. TIME OF INJURY (e.g. 1:10 p.m.): | 45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY<br>47. HAS EMPLOYEE RETURNED TO WORK? • YES • NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY |
|---|---|---|---|

| 48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis): | 49. BODY PART(s) AFFECTED (e.g. lower right forearm): | 50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate): |
|---|---|---|

| 51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? • YES • NO | 52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.): |
|---|---|

| 53. HOSPITALIZED OVERNIGHT AS INPATIENT? • YES • NO | 54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? • YES • NO | 55. HEALTH CARE PROVIDER NAME: | 56. MAILING ADDRESS: | 57. TELEPHONE NUMBER: ( ) |
|---|---|---|---|---|

## PREPARER INFORMATION

| 58. PREPARER NAME AND TITLE (TYPE OF PRINT): | 59. TELEPHONE NUMBER: ( ) | 60. DATE SENT TO WCB: ____/____/____ MM DD YYYY |
|---|---|---|

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES.
THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.

**First Report of Injury (FROI) – WCB-1**

**DUE DATE** - file electronically within seven days of notice/knowledge of a work-related injury which has caused the employee to lose a day's work.

**Box 2b - Was employee paid for ½ day on day of injury?** - Make sure this is accurate! It affects the calculation of the waiting period, compensability, and indemnity benefits. (If paid for ½ day or more, the date of injury is NOT a compensable day of incapacity).

**Box 42 - Date of injury or illness**

- Date of injury - date accident occurred (traumatic injury) or date of last exposure (cumulative injury or occupational disease).
- Date employer notified - the date the employer had notice or knowledge of the injury.

**Box 43 - Date of incapacity**

- Date of incapacity - first day qualifying as a day of incapacity/disability in the first period of incapacity/disability.
- Date employer notified - date that the employer had notice or knowledge of the work-related incapacity/disability in the first period or incapacity/disability. In the case of sporadic incapacity, enter the date that the employer had notice or knowledge of a day or more collectively lost from work.

**Box 45 - Date employer notified insurer/TPA** - Earliest date insurer or administrator had notice of the injury from any source. (For most filing/payment deadlines, the day employer had notice or knowledge starts the clock ticking regardless of when insurer/administrator was notified).

**Box 47 - Has employee returned to work?** - Must report "yes" or "no" if Box 2a is checked (there is lost time). If days lost are less than or equal to 7, the actual RTW date must be reported within 7 days of RTW with FROI 02 transaction. Not required if more than 7 days lost.

**General**

- Typical TE's – Employer physical address contains P.O. Box, FEIN problem, addresses don't match.
- The paper copy to the employee must be materially the same as the one filed EDI with the Board.
- Employers must report ALL injuries, including medical only injuries to their insurer.

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

# WAGE STATEMENT

1. REVISION DATE: _____/_____/_____ MM DD YYYY

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: | |

20. DOES EMPLOYEE WORK CONCURRENTLY? ☐ YES ☐ NO IF YES, A WAGE STATEMENT MUST BE SUBMITTED FOR EACH EMPLOYER

NAME(S) OF EMPLOYERS: _____ ; _____ ; _____

21. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? ☐ YES ☐ NO

IF YES: THE AVERAGE WEEKLY WAGE MUST BE RECALCULATED IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))

22. METHOD OF CALCULATION:
☐ 102(4)(A) – SALARIED
☐ 102(4)(B) – VARYING WAGES
☐ 102(4)(C) – SEASONAL WORKER
☐ 102(4)(D) – OTHER*

* NOTE: IF WAGES WERE CALCULATED USING SECTION 102(4)(D), YOU MUST SUBMIT COMPARABLE WAGES WITH THIS FILING AND PROVIDE A DETAILED EXPLANATION OF THE CALCULATION IN THE COMMENTS BOX.

## 23. LIST GROSS EARNINGS FOR EACH WEEK:

| WK 1 | WEEK ENDING | GROSS EARNINGS | WK 19 | WEEK ENDING | GROSS EARNINGS | WK 37 | WEEK ENDING | GROSS EARNINGS |
|---|---|---|---|---|---|---|---|---|
| 2 | | | 20 | | | 38 | | |
| 3 | | | 21 | | | 39 | | |
| 4 | | | 22 | | | 40 | | |
| 5 | | | 23 | | | 41 | | |
| 6 | | | 24 | | | 42 | | |
| 7 | | | 25 | | | 43 | | |
| 8 | | | 26 | | | 44 | | |
| 9 | | | 27 | | | 45 | | |
| 10 | | | 28 | | | 46 | | |
| 11 | | | 29 | | | 47 | | |
| 12 | | | 30 | | | 48 | | |
| 13 | | | 31 | | | 49 | | |
| 14 | | | 32 | | | 50 | | |
| 15 | | | 33 | | | 51 | | |
| 16 | | | 34 | | | **WK OF INJURY** | | |
| 17 | | | 35 | | | **24. TOTAL EARNINGS** | | **$** |
| 18 | | | 36 | | | **25. GROSS AVERAGE WEEKLY WAGE** | | **$** |

26. COMMENTS:

| 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.

**Wage Statement – WCB-2**

**DUE DATE** - Within 30 days of notice/knowledge of a claim for compensation. (Box 22 of the MOP or Box 22 of the NOC).

**Box 20 - Concurrent employer** - Obtain separate wage statements for each employer. The employer for whom the employee worked at the time of injury is required to obtain and file the WCB-2(s) from the other employer(s). A concurrent employer is one who the employee had an employment relationship with at the time of the injury, whether or not they were actually working for them.

**Box 21 - Fringe benefits** - added to AWW only if discontinued during incapacity. Per Rule 1.5(2)(B), the AWW must be recalculated when fringe benefits cease. Form WCB-2B, Fringe Benefits Worksheet, must also be filed whether "yes" or "no" is checked.

**Box 22 – Method of Calculation**

- 102(4)(A) – earnings are generally the same each week
- 102(4)(B) - omit week of hire and/or week of injury if either or both reduce AWW. (Include any omitted weeks in Box 24, just omit from your calculation and note in Box 26.)
- 102(4)(C) – Employer must be a seasonal employer. Must use prior calendar years earnings.
- 102(4)(D) – Must submit at least two comparables and provide a detailed explanation of calculation in the comment box.

**Box 23 - Gross wages for each week**

- Must be actual earnings, estimates are not accepted.
- If the employee is paid on other than a weekly basis, the form may be filled out on that basis (bi- weekly, monthly, etc.). However, actual earnings should be shown for the week of hire and week of injury, as well as any weeks with NO earnings.
- Include reported tips for tipped employees.
- Use payroll week ending dates, not check issue dates.
- Must be completed even if worksheet attached.
- Week 52 is the week that includes the injury; work backward to week 1.
- Include all weeks, even if there are no earnings. Do not go back more than 52 weeks.

**Box 24-Total earnings** -This must be the total of all earnings for the 52 week period, even if not all are used in calculating the AWW. Please note on Box 26 of the form if you left out any weeks in the AWW calculation (week of injury, for example).

**General**

- Please review all wage statements for accuracy.
- Be careful when faxing - if it can't be read, it will be returned to you.
- Include preparer name and email address (Box 27).

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

# FRINGE BENEFITS WORKSHEET

| 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: | |

**PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).**

**NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.**

| 20. Fringe Benefit | Provided | Continues while Employee is out of work | Date Benefits End | Weekly Cost of Benefits to Employer |
|---|---|---|---|---|
| Health Benefits (incl. insurance) | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Dental Insurance | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Disability Insurance (incl. short and long term) | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| 401K | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Life Insurance | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Education/Training | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Pension | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Other (please list): | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |
| Other (please list): | Yes ☐ No ☐ | Yes ☐ No ☐ | | $ |

| 21. TYPE OR PRINT PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED): | 22. TELEPHONE NUMBER (REQUIRED): ( ) | 23. DATE MAILED: _____/_____/_____ MM DD YYYY |
|---|---|---|

**Fringe Benefits Worksheet – WCB-2B**

**DUE DATE** - Within 30 days of notice/knowledge of a claim for compensation. (Box 22 of MOP or Box 22 of NOC.)

**Box 20 - Fringe benefits** - Provide the cost of the fringe benefit paid by the employer as of the employee's date of injury if the employee was receiving the benefit on their date of injury (see Rule 1.5.1). NOTE: the amounts reported are subject to verification by the employee and their representative and documentation must be provided upon request.

**General**

- The WCB-2B is required to accompany ALL Wage Statements (WCB-2) filed on or after 1/1/2013, regardless of date of injury. A WCB-2B is required to be filed for concurrent employers, as well as the employer of injury.
- Any benefit checked as "yes" in the "provided" column must also be checked "yes" or "no" in the "continues" column and have a dollar amount in the "weekly cost" column, or a percentage in the case of a 401(k).
- Benefits calculated based on AWW including lost fringe benefits are subject to a maximum rate of 2/3 the SAWW at the time of injury. If benefits based on AWW without lost fringes are higher, pay the higher amount.
- Per change effective 9/1/18 to Rule 1.5.1.A.3, inclusion of 401(k), 403(b) and equivalent plans ends when the employee returns to work.

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

# MEMORANDUM OF PAYMENT

1.REVISION DATE: _____/_____/_____ MM DD YYYY

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 MAKING THE FIRST PAYMENT OF COMPENSATION FOR INCAPACITY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

- ☐ YOUR CLAIM IS ACCEPTED
- ☐ THIS IS A VOLUNTARY PAYMENT (PAYMENT WITHOUT PREJUDICE)
- ☐ THIS IS A MANDATORY PAYMENT PURSUANT TO RULE 1.1 AND §205(2) AMOUNT PAID $ _____

PAYMENT FROM (DATE CLAIM MADE) _____/_____/_____ MM DD YYYY PAYMENT THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) _____/_____/_____ MM DD YYYY

| 21. PAYMENT TYPE: | 22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET: | 23. DATE OF INCAPACITY: | 24. DATE CHECK MAILED: |
|---|---|---|---|
| ☐ WEEKLY COMPENSATION<br>☐ SPECIFIC LOSS: _____ WEEKS<br>☐ SALARY CONTINUATION<br>☐ OTHER (EXPLAIN): _____ | _____/_____/_____ MM DD YYYY | _____/_____/_____ MM DD YYYY<br>DATE EMPLOYER NOTIFIED OF INCAPACITY:<br>_____/_____/_____ MM DD YYYY | _____/_____/_____ MM DD YYYY |

| 25. AVERAGE WEEKLY WAGE: | 26. BENEFIT TYPE: | 27. NET CHECK AMOUNT (AFTER OFFSETS): |
|---|---|---|
| $ _____ | ☐ TOTAL INCAPACITY (§212)<br>☐ PARTIAL INCAPACITY (§213)<br>☐ FATAL (§215/§355 (14) (F)) | ☐ FIXED $ _____<br>THIS AMOUNT IS EQUAL TO THE EMPLOYEE'S WEEKLY COMPENSATION RATE MINUS OFFSETS REPORTED IN BOX 27A.<br>☐ VARYING |

27A. NET CHECK AMOUNT REDUCED FOR (OFFSETS):

| | | | |
|---|---|---|---|
| ☐ APPORTIONMENT (§354) | $_____ | ☐ SOCIAL SECURITY RETIREMENT (§221(3)(A)(1)) | $_____ |
| ☐ DISABILITY INSURANCE (§§221(3)(A)(2)-(3)) | $_____ | ☐ THIRD PARTY LIABILITY (§107) | $_____ |
| ☐ EARNINGS FROM SAME EMPLOYER | $_____ | ☐ UNEMPLOYMENT COMPENSATION (§220) | $_____ |
| ☐ EMPLOYER FUNDED PENSION (§ 221(3)(A)(5)) | $_____ | ☐ WAGE CONTINUATION PLAN (§221(3)(A)(2)) | $_____ |
| ☐ PAID TIME OFF (§§221(3)(A)(2)) | $_____ | ☐ OTHER:_____ | $_____ |

27B. IF THIS IS AN APPORTIONMENT CLAIM, PLEASE COMPLETE THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: _____

OTHER INSURER(S) INVOLVED: _____

TERMS OF THE APPORTIONMENT:_____

28. COMMENTS:

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

| AUGUSTA | BANGOR | CARIBOU | LEWISTON | PORTLAND |
|---|---|---|---|---|
| 442 CIVIC CTR. DRIVE, STE 225<br>156 STATE HOUSE STATION<br>AUGUSTA, ME 04333-0156<br>(207) 287-2308<br>1-800-400-6854 | 396 GRIFFIN RD, STE 105<br>BANGOR, ME<br>04401-5638<br>(207) 941-4550<br>1-800-400-6856 | ONE VAUGHN PL<br>43 HATCH DR, STE 110<br>CARIBOU, ME 04736<br>(207) 498-6428<br>1-800-400-6855 | 36 MOLLISON WAY<br>LEWISTON, ME<br>04240-7777<br>(207) 753-7700<br>1-800-400-6857 | 56 NORTHPORT DR, STE 201<br>PORTLAND, ME<br>04103<br>(207) 822-0840<br>1-800-400-6858 |

| 29. PREPARER'S FULL NAME (REQUIRED):<br>E-MAIL ADDRESS (REQUIRED): | 30. TELEPHONE NUMBER (REQUIRED):<br>( )<br>TOLL-FREE NUMBER:<br>( ) | 31. DATE SENT TO WCB:<br>_____/_____/_____ 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.

**Memorandum of Payment – WCB-3**

**DUE DATE** - Within 14 days of notice/knowledge of incapacity or 6 days from Box 22 of MOP (broken period).

**Box 20- Reason for payment** - Be careful about checking 20A! This creates a "compensation scheme" (payment with prejudice), meaning that unless the employee returns to work you cannot reduce or discontinue benefits without an order from the Board.

**Box 21-Type of payment**

- If "specific loss" is checked, enter the number of weeks payable.
- If "other" is checked, describe the type of payment, e.g. Permanent Impairment (pre-1993).

**Box 22 - First day of compensability**

- The date that the employee was incapacitated beyond the waiting period and/or was entitled to indemnity benefits (sometimes referred to as "day 8").
- Complete if current incapacity is subject to 7 day waiting period or employee is a firefighter. Need not be completed for subsequent periods of incapacity from the same injury.
- For salary continuation, complete as if the employee has lost the wage that is being continued during the time absent, or when the hours missed equals hours in a regular work week.
- For partial incapacity, waiting period may be determined by lost wages (AWW method) or lost benefits (WCR method). Other methods may be acceptable.

**Box 23**

**Date of Incapacity** - Initial date disability began as reported on the FROI.
**Date Employer Notified of Incapacity** - Date employer notified of the incapacity, not the injury. Can not pre-date the date of incapacity above and should match what was reported on the FROI.

**Box 24 - Date check mailed** - Date check is mailed, *not processed*. For salary continuation, date payroll check is mailed/delivered/direct deposited.

**Box 27**

- Check the FIXED box if the employee will be paid at a fixed rate (total or partial).
- If fixed rate is selected, enter the dollar amount of the current compensation rate (or the applicable maximum) after offsets.

- For cases involving salary continuation, enter the compensation rate that would otherwise be paid (or the applicable maximum) after offsets.
- Check the PARTIAL box if the employee will be paid at varying rates.

**General**

- Must be closed with a discontinuance via a WCB-4D, a WCB-4A, or a WCB-8.
- If a provisional MOP was filed initially and the actual rate is greater than the provisional rate, an amended MOP (WCB-3) must be filed to establish the correct average weekly wage and weekly compensation rate (no MOD required).
- Effective 9/1/18- If a provisional MOP was filed initially and the actual rate is less than the provisional rate, the AWW may be adjusted by filing a MOD ONCE within 90 days from initial lost time payment to correct an error or miscalculation. If it is beyond 90 days, a (21-Day) Certificate of Discontinuance or Reduction of Compensation (WCB-8) must be filed to establish the correct AWW and WCR, and the higher rate paid for the 21 days.
- If the maximum rate is used, enter employee's own rate in the comment section (Box 28).

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

| 1. REVISION DATE: _____/_____/_____ MM DD YYYY | **DISCONTINUANCE 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 BENEFITS ARE BEING DISCONTINUED FOR THE REASON MARKED BELOW. IF YOU DISAGREE OR HAVE QUESTIONS, PLEASE CONACT THE BOARD AT ONE OF THE REGIONAL OFFICES LISTED BELOW.

- ☐ RETURNED TO WORK FOR SAME EMPLOYER REGULAR / FULL DUTY MEDICAL RELEASE (RULES CH. 8, §11(2))
- ☐ RETURNED TO WORK FOR SAME EMPLOYER EARNING AT / ABOVE AVERAGE WEEKLY WAGE (§205(9)(A))
- ☐ AGREEMENT OF THE PARTIES / BOARD DECISION (RULES, CH. 8 §12)
- ☐ LUMP SUM SETTLEMENT
- ☐ NOC FILED WITHIN 45 DAYS PURSUANT TO (§205(2)(2))
- ☐ OTHER (EXPLAIN):_____

21. PERIOD OF INCAPACITY:

FROM (DATE): _____/_____/_____ MM DD YYYY

THROUGH (DATE): _____/_____/_____ MM DD YYYY

22. NET WEEKLY CHECK AMOUNT FROM MEMORANDUM OF PAYMENT OR MOST RECENT MODIFICATION:

$_____

23. TOTAL WEEKLY COMPENSATION PAID FOR THE PERIOD OF INCAPACITY IN BOX 21:

$_____

24. DATE THE FINAL PAYMENT WAS MAILED:

_____/_____/_____ MM DD YYYY

25. COMMENTS:

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

| **AUGUSTA** | **BANGOR** | **CARIBOU** | **LEWISTON** | **PORTLAND** |
|---|---|---|---|---|
| 442 CIVIC CTR DR, STE 225<br>156 STATE HOUSE STATION<br>AUGUSTA, ME 04333-0156<br>(207) 287-2308<br>1-800-400-6854 | 396 GRIFFIN RD, STE 105<br>BANGOR, ME<br>04401-5638<br>(207) 941-4550<br>1-800-400-6856 | ONE VAUGHN PL<br>43 HATCH DR, STE 110<br>CARIBOU, ME 04736<br>(207) 498-6428<br>1-800-400-6855 | 36 MOLLISON WAY<br>LEWISTON, ME<br>04240-7777<br>(207) 753-7700<br>1-800-400-6857 | 56 NORTHPORT DR, STE 201<br>PORTLAND, ME<br>04103<br>(207) 822-0840<br>1-800-400-6858 |

| 26. PREPARER'S FULL NAME (REQUIRED):<br><br>E-MAIL ADDRESS (REQUIRED): | 27. TELEPHONE NUMBER (REQUIRED):<br>( )<br>TOLL-FREE NUMBER:<br>( ) | 28. DATE SENT TO WCB:<br>_____/_____/_____ 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.

**Discontinuance of Compensation – WCB-4D**

**DUE DATE** - Within 14 days after benefits are discontinued under §205(9)(A) (return to work or an increase in pay with the employer of injury) or §205(9)(B)(2) (order or award of compensation).

**Box 21** - Period of incapacity

- "From" date should be the same as Box 23a of the MOP.
- "Through" date should be up to and including the last day paid.
- Only one period of incapacity should be entered per form.

**Box 22 – Net Weekly Check Amount** - Should be the same as MOP Box 27 or MOD Box 24.

**Box 23 - Amount paid** - Total amount paid for this period of incapacity. Do not reduce by any recoveries, and do not include any interest or penalties.

**Box 24 - Date final payment mailed** - Date last benefit payment was mailed, not processed.

**General** - There must be an actual return to work with the employer of injury to discontinue with a WCB-4D. See change to Rule Chapter 8 Section11(2)(C) regarding what is considered a return to work effective 9/1/18.

**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 INCAPACITY (§212) |
| ☐ SPECIFIC LOSS _____ WEEKS | ☐ PARTIAL INCAPACITY (§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 | ONE VAUGHN PL | 36 MOLLISON WAY | 56 NORTHPORT DR, STE 201 |
| 156 STATE HOUSE STATION | BANGOR, ME | 43 HATCH DR, STE 110 | 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.

**Modification of Compensation – WCB-4M**

**DUE DATE** -Within 14 days after benefits are modified under §205(9)(A) (return to work or an increase in pay with the employer of injury) or §205(9)(B)(2) (order or award of compensation).

**Box 23 - Old weekly check amount** - Rate prior to modification. This should match the new rate on the previously filed modification. If varying, enter "varying."

**Box 24 - New weekly check amount** - Rate following modification. If varying, enter "varying."

**Box 25 - Effective date** - Date modification became effective, not the date the check was issued.

**General**

- A modification must be filed when the benefit is modified due to a max rate increase.
- Wage continuation plan is not salary continuation.
- Discuss other problem areas in Box 20, especially new items like change in payment type.

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

# CONSENT BETWEEN EMPLOYER AND EMPLOYEE

| 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: | |

| 20. TERMS OF CONSENT: | | | |
|---|---|---|---|
| 20A. DATE OF INCAPACITY: | 20B. AVERAGE WEEKLY WAGE: | 20C. CURRENT WEEKLY COMPENSATION RATE: TOTAL ☐ PARTIAL ☐ | 20D. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): YES ☐ NO ☐ |
| 20E. NEW COMPENSATION RATE: | 20F. EFFECTIVE DATE OF REDUCTION: | 20G. EFFECTIVE DATE OF DISCONTINUANCE: | 20H. AMOUNT PAID: |

## NOTICE TO EMPLOYEE (Please read and initial)

21. BEFORE YOU SIGN THIS FORM, YOU SHALL CALL THE WORKERS' COMPENSATION BOARD'S OFFICES TO FIND OUT WHAT RIGHTS YOU HAVE IF YOU SIGN THIS FORM. A LIST OF THE BOARD'S REGIONAL OFFICES IS SHOWN AT THE BOTTOM OF THIS PAGE.

EMPLOYEE INITIALS: _____

## NOTICE TO EMPLOYER

THIS FORM SHALL NOT BE USED FOR CASES WHEN AN ORDER, AWARD OF COMPENSATION OR A COMPENSATION SCHEME WAS ENTERED UNDER SECTION 205 (9)(B)(2).

## CONSENT

22. WE AGREE TO THE TERMS LISTED IN BOX 20 ABOVE. WE UNDERSTAND THAT THIS IS NOT A FINAL SETTLEMENT. SIGNING THIS CONSENT FORM CREATES A PAYMENT WITHOUT PREJUDICE, DOES NOT CREATE A PAYMENT SCHEME, AND DOES NOT PREVENT EITHER PARTY FROM REOPENING THE CLAIM WITHIN CERTAIN TIME LIMITS. THIS FORM MUST BE SIGNED BY THE EMPLOYEE, EMPLOYEE'S ATTORNEY OR WORKER ADVOCATE IF ANY, AND THE EMPLOYER/INSURER OR BY A DULY AUTHORIZED REPRESENTATIVE.

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____
EMPLOYEE 'S AUTHORIZED REPRESENTATIVE SIGNATURE (IF APPLICABLE) DATE

_____ _____
EMPLOYER/INSURER OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

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

| **AUGUSTA** | **BANGOR** | **CARIBOU** | **LEWISTON** | **PORTLAND** |
|---|---|---|---|---|
| 442 CIVIC CTR DR, STE 225<br>156 STATE HOUSE STATION<br>AUGUSTA, ME 04333-0156 (207) 287-2308<br>1-800-400-6854 | 396 GRIFFIN RD, STE105<br>BANGOR, ME<br>04401-5638<br>(207) 941-4550<br>1-800-400-6856 | ONE VAUGHN PL<br>43 HATCH DR, STE 110<br>CARIBOU, ME 04736<br>(207) 498-6428<br>1-800-400-6855 | 36 MOLLISON WAY<br>LEWISTON, ME<br>04240-7777<br>(207) 753-7700<br>1-800-400-6857 | 56 NORTHPORT DR, STE 201<br>PORTLAND, ME<br>04103<br>(207) 822-0840<br>1-800-400-6858 |

| 23. PREPARER NAME AND TITLE (TYPE OR PRINT): | 24. TELEPHONE NUMBER: | 25. DATE MAILED: |
|---|---|---|

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.

**Consent Between Employer and Employee – WCB-4A**

**DUE DATE** - No specific due date for the form itself, but payment is due within 10 calendar days after being signed by all parties.

**General**

- May be used when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification, reduction or discontinuance in ongoing weekly incapacity benefits.
- Shall not be used to reduce or discontinue benefits on a date subsequent to the date signed.
- Best practice - don't sign until the employee signs and returns.
- The parties may agree to the pre-injury average weekly wage or may agree to pay benefits based upon a provisional wage and reserve the issue of the pre-injury average weekly wage for later determination by the Board. In either event, the form shall also indicate whether the employee is receiving 100% of the benefits at issue for the designated period, if the employee is receiving less than 100% of the benefits at issue for the designated period, the form shall indicate the percentage of benefits that the employee is receiving.
- All wage forms are still required to be filed.
- Upon request by any of the parties, the Consent Between Employer and Employee, WCB-4A, shall be reviewed within 14 calendar days by an agent at the Board's regional offices in order to answer any relevant questions prior to the employer and employee signing this form.
- Shall not be used when an order or award is entered under 205(9)(8)(2).
- Signing the WCB-4A does not by itself create a compensation scheme.

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

| 1. REVISION DATE: _____/_____/_____ MM DD YYYY | **CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION PURSUANT TO 39-A M.R.S.A. 205(9)(B)(1)** | 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: | |

## NOTICE TO EMPLOYEE

YOUR WEEKLY COMPENSATION BENEFITS WILL BE DISCONTINUED OR REDUCED 21 DAYS FROM THE DATE THIS CERTIFICATE WAS MAILED BASED ON THE ATTACHED INFORMATION. IF YOU DISAGREE WITH THIS ACTION, YOU MAY FILE A PETITION FOR REVIEW AND REQUEST REINSTATEMENT OF YOUR BENEFITS PENDING HEARING, UNDER 39-A M.R.S.A. §205(9)(C). YOUR PETITION AND REQUEST (ON FORM WCB-121) MUST BE MAILED TO THE WORKERS' COMPENSATION BOARD ADDRESS ABOVE.

20. REASON FOR DISCONTINUANCE OR REDUCTION (MUST ATTACH SUPPORTING DOCUMENTATION):

## DISCONTINUANCE

| 21. PERIOD OF INCAPACITY:<br>FROM (DATE):<br>THROUGH (DAY BEFORE EFFECTIVE DATE OF DISCONTINUANCE): | 22. WEEKLY COMPENSATION RATE: | 23. COMPENSATION PAID TO DATE OF CERTIFICATE: | 24. COMPENSATION TO BE PAID FOR 21 DAY PERIOD: |
|---|---|---|---|

## REDUCTION

| 25. OLD COMPENSATION RATE: | 26. NEW COMPENSATION RATE: | 27. EFFECTIVE DATE OF REDUCTION: |
|---|---|---|

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

| AUGUSTA | BANGOR | CARIBOU | LEWISTON | PORTLAND |
|---|---|---|---|---|
| 442 CIVIC CTR DR, STE 225<br>156 STATE HOUSE STATION<br>AUGUSTA, ME 04333-0156<br>(207) 287-2308<br>1-800-400-6854 | 396 GRIFFIN RD, STE 105<br>BANGOR, ME<br>04401-5638<br>(207) 941-4550<br>1-800-400-6856 | ONE VAUGHN PL<br>43 HATCH DR, STE 110<br>CARIBOU, ME 04736<br>(207) 498-6428<br>1-800-400-6855 | 36 MOLLISON WAY<br>LEWISTON, ME<br>04240-7777<br>(207) 753-7700<br>1-800-400-6857 | 56 NORTHPORT DR, STE 201<br>PORTLAND, ME<br>04103<br>(207) 822-0840<br>1-800-400-6858 |

| 28. TYPE OR PRINT PREPARER NAME (REQUIRED):<br>E-MAIL ADDRESS (REQUIRED): | 29. TELEPHONE NUMBER (REQUIRED): ( )<br>TOLL-FREE NUMBER: ( ) | 30. DATE MAILED (MUST MATCH POSTMARK): _____/_____/_____ 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.

**(21 DAY) CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION - WCB-8**

Use if benefits are discontinued or reduced for any reason other than those which allow the filing of a WCB-4D unless indemnity is being paid pursuant to an order or award, or compensation scheme.

**DUE DATE** - File by certified mail no later than 21 days prior to the effective date of the discontinuance or modification.

**Box 20** - Reason for discontinuance - Enter reason and attach supporting documentation.

**Box 21** - Period of incapacity

- "From" date should be the same as Box 23 of the MOP.
- "Through" date is the day before the effective date of discontinuance (no earlier than 21 days from Box 30).
- Only one period of incapacity should be entered per form.

**Box 22- WCR** - If more than one rate was used, enter last rate used.

**Box 23- Compensation paid** - Total amount paid or due to the date the form is mailed for the current period of incapacity. This should be a dollar amount. Do not reduce by any recoveries. For salary continuation, do not include amounts paid by the employer.

**Box 24 - Compensation paid for the 21 day period** - Total amount anticipated to be paid for the 21 day notice period. This should be a dollar amount. Note Boxes 23 and 24 should equal the total weekly compensation paid for the period listed in Box 21.

**Box 25 - Old compensation rate** - Rate prior to modification. If varying, enter "varying."

**Box 26 - New compensation rate** - Rate following modification. If varying, enter "varying."

**Box 27 - Effective date of reduction** - Date payment for incapacity will be reduced (no earlier than 21 days from Box 30).

**General**

- Send certified mail to WCB and employee on date of mailing shown in Box 30.
- Be sure to get post-marked receipts from the post office upon mailing.
- Do not count the day form is mailed in calculating the 21 days. For example, if mailed May 5 (Box 30), add 21 days and use effective date of May 26 in Box 21 or 27.
- A cover letter should accompany the WCB-8 which includes the certified mail number.
- Use form 231-A to take an offset for earnings with a different employer.

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

# NOTICE OF CONTROVERSY
# THIS IS A DENIAL OF YOUR BENEFITS

| 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: | |

20. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

21a. **FULL DENIAL REASON**

21b. **PARTIAL DENIAL REASON**

22a.

DATE OF INITIAL INCAPACITY ____/____/____

CURRENT DATE OF INCAPACITY ____/____/____

22b.

DATE EMPLOYER NOTIFIED _____/_____/_____

FULL DENIAL EFFECTIVE DATE _____/_____/_____

*NOTE: Reasons identified in boxes 21a or 21b will not preclude a party from raising additional issues at a later date.

23. COMMENTS:

24. ANY EMPLOYER OR INSURER THAT FAILS TO FILE A NOTICE OF CONTROVERSY IN A TIMELY FASHION AS REQUIRED BY 39-A M.R.S. § 205 (2) MAY BE OBLIGATED TO PAY PENALTIES AS REQUIRED BY THE WORKERS' COMPENSATION ACT AND RULES. QUESTIONS PERTAINING TO THIS OBLIGATION MAY BE DIRECTED TO A CLAIMS RESOLUTION SPECIALIST AT ONE OF THE REGIONAL OFFICES LISTED BELOW.

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

| AUGUSTA | BANGOR | CARIBOU | LEWISTON | PORTLAND |
|---|---|---|---|---|
| 442 CIVIC CTR DR, STE 225<br>156 STATE HOUSE STATION<br>AUGUSTA, ME 04333-0156<br>(207) 287-2308<br>1-800-400-6854 | 396 GRIFFIN RD, STE 105<br>BANGOR, ME<br>04401-5638<br>(207) 941-4550<br>1-800-400-6856 | ONE VAUGHN PL<br>43 HATCH DR, STE 110<br>CARIBOU, ME 04736<br>(207) 498-6428<br>1-800-400-6855 | 36 MOLLISON WAY<br>LEWISTON, ME<br>04240-7777<br>(207) 753-7700<br>1-800-400-6857 | 56 NORTHPORT DR, STE 201<br>PORTLAND, ME<br>04103<br>(207) 822-0840<br>1-800-400-6858 |

| 25. TYPE OR PRINT NAME (REQUIRED): | 26. TELEPHONE # (REQUIRED): | 27. DATE SENT TO WCB: |
|---|---|---|
| E-MAIL ADDRESS (REQUIRED): | ( ) | 28. DATE RCVD AT WCB (WCB use only): |

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-9 (effective 9/1/2020, revised 12/4/2023)

**Notice of Controversy – WCB-9**

**DUE DATE** - File electronically within 14 days of notice/knowledge of a claim for incapacity or death benefits. For denial of medical benefits only, file within 30 days of notice/knowledge of claim for medical benefits.

**Box 21a - Full denial reason** - Code 1 through 5 (see Forms Manual). Also enter denial effective date.

**Box 21b - Partial denial reason** - Code A through G (see Forms Manual).

**Box 22a**

- Date of initial incapacity - first day qualifying as a day of disability.
- Current date of incapacity - first qualifying day of disability in the current period of disability being denied. If the same as above, leave blank.

**Box 22b - Date Employer Notified** – is for the current date of incapacity.

**Box 23 - Comments** - Use for additional information, explanations, or clarifications. If disability has been intermittent or sporadic, it should be noted here.

**General**

- NOC revisions cannot be filed electronically. Must be filed via email, fax, mail or in-hand delivery.
- Original NOCs must be via EDI, paper filings will be discarded, and notice of this action may not be given.
- A NOC cannot change the injury code type for the claim. To do this, a FROI-02 must be filed via EDI.
- A WCB-2 and WCB-2B must be filed within 30 days of employer notice or knowledge (Box 22b).
- If a NOC is filed on a medical only claim and it later becomes a lost time claim, a new NOC must be filed to dispute indemnity.
- If a lost time NOC is filed, it can NOT be revised to medical only, even if there is no lost time. The WCB-2 and WCB-2B must be filed.
- If filed late, benefits must be paid, with credit for earnings and other statutory offsets, from the date the claim was made through the date the NOC is filed (and accepted), and payment made. A mandatory MOP must be filed.
- The copy to the employee must be materially the same as the one filed EDI with the Board (pdf file now being sent with the AKC report).

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

# STATEMENT OF COMPENSATION PAID

| 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: | |

20. REASON FOR REPORT:

☐ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND) ☐ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

## PAYMENT SUMMARY

**21. LIST CUMULATIVE TOTALS (DO NOT INCLUDE PENALTY AMOUNTS):**

| | | | |
|---|---|---|---|
| **MEDICAL TREATMENT** | $ | **DEATH BENEFIT/FUNERAL EXPENSE** (NOT TO EXCEED $7,000) | $ |
| **WEEKLY COMPENSATION** | $ | **EMPLOYEE RELATED LEGAL EXPENSE** | $ |
| **PERMANENT IMPAIRMENT** (PRE 1993 ONLY) | $ | **EMPLOYER RELATED LEGAL EXPENSE** | $ |
| **EMPLOYMENT REHABILITATION** | $ | **INTEREST AND OTHER PAYMENTS** | $ |
| **LUMP SUM SETTLEMENT** | $ | | |
| | | **TOTAL AMOUNT PAID** (DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES.) | $ |

**COMMENTS:**

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

| AUGUSTA | BANGOR | CARIBOU | LEWISTON | PORTLAND |
|---|---|---|---|---|
| 442 CIVIC CTR. DRIVE, STE 225<br>156 STATE HOUSE STATION<br>AUGUSTA, ME 04333-0156<br>(207) 287-2308<br>1-800-400-6854 | 396 GRIFFIN RD, STE 105<br>BANGOR, ME<br>04401-5638<br>(207) 941-4550<br>1-800-400-6856 | ONE VAUGHN PL<br>43 HATCH DR, STE 110<br>CARIBOU, ME 04736<br>(207) 498-6428<br>1-800-400-6855 | 36 MOLLISON WAY<br>LEWISTON, ME<br>04240-7777<br>(207) 753-7700<br>1-800-400-6857 | 56 NORTHPORT DR, STE 201<br>PORTLAND, ME<br>04103<br>(207) 822-0840<br>1-800-400-6858 |

| 22. PREPARER'S FULL NAME (REQUIRED):<br><br>E-MAIL ADDRESS (REQUIRED): | 23. TELEPHONE NUMBER (REQUIRED):<br>( )<br>TOLL-FREE NUMBER:<br>( ) | 24. DATE SENT TO WCB:<br><br>_____/_____/_____<br>MM DD YYYY |
|---|---|---|

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WCB-11A Effective 04/01/2025

**Statement of Compensation Paid – WCB-11**

**DUE DATE** –

- Initial report due within 195 days of date of injury.
- Annual - within 15 days of each anniversary date of the injury if payments of any type were made since the previous SOC.
- Final - no further payments are anticipated.
- Not required if no indemnity benefits were ever paid.
- Not required if all indemnity paid was salary continuation.

**Box 20 - Reason for report** - Indicate interim (ongoing payments of any kind) or final (no further payments anticipated).

**Box 21 - Cumulative totals**

- Do not include any penalty amounts, nor reduce any totals by the amount of any recoveries.
- For salary continuation, do not include amounts paid by the employer.
- Medical - Does not include expenses related to managed care services such as utilization review, case management, and bill review, or to exams performed pursuant to §207 and §312.
- Weekly Compensation - Sum of all indemnity benefits, specific loss benefits, and mandatory indemnity payments. When filing this form as a final, this amount must match the sum of the Amount Paid on all payment forms.
- Permanent Impairment - For injuries prior to 1993 only.
- Employment Rehabilitation - Employment rehabilitation expenses paid.
- Lump Sum Settlement - This amount must match the approved amount on form WCB-10. Include the amount of any Medicare Set-Aside.
- Death Benefit/Funeral Expense - Cannot exceed $7,000.00.
- Legal Expense - the sum of all legal expenses paid for the claim - separated into employee related and employer related expenses.
- Interest and Other Payments - Payments not otherwise reported for this claim, such as surveillance, mileage, expert witness fees, court reporter fees, private investigator fees, medical and other travel costs related to managed care services such as utilization review, case management, and bill review, and exams pursuant to §207 and §312.

**General** - When amounts decrease, the comment box can indicate the reason. This will limit clarification requests from the Board.

**Additional resources from the Maine Workers' Compensation Board**

You will find many valuable resources on our website, including all Board forms in fillable PDF format, EDI information, laws, rules, newsletters, compliance reports, training modules, benefit tables, fee schedules, and regional office locations.

www.Maine.gov/wcb

For more information on our training and outreach programs contact Amanda DiPietro, 207-287-6327, or Amanda.DiPietro@Maine.gov