

# MEMORANDUM OF PAYMENT

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

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 WORKERS' COMPENSATION FORM UPON PAYMENT OF A LOST TIME WORK-RELATED INJURY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

- A.  YOUR CLAIM IS ACCEPTED.
- B.  THIS IS A VOLUNTARY PAYMENT WITHOUT PREJUDICE.
- C.  THIS IS A MANDATORY PAYMENT PURSUANT TO RULE 1.1. AMOUNT PAID \$ \_\_\_\_\_. PERIOD COVERED BY MANDATORY PAYMENT:  
FROM (DATE CLAIM MADE) \_\_\_\_/\_\_\_\_/\_\_\_\_ THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

21. TYPE OF PAYMENT:

A.  WEEKLY COMPENSATION

B.  SPECIFIC LOSS: \_\_\_\_\_ WEEKS

C.  OTHER (EXPLAIN): \_\_\_\_\_

22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET:  
  
\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

23. DATE OF INCAPACITY: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

DATE EMPLOYER NOTIFIED OF INCAPACITY: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

24. DATE CHECK MAILED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

25. AVERAGE WEEKLY WAGE: \$ \_\_\_\_\_

26. CURRENT WEEKLY COMPENSATION RATE:  
 TOTAL  PARTIAL  
\$ \_\_\_\_\_  
(IF VARYING RATES ARE BEING PAID, ENTER THE WORD "VARYING")

27. IS THIS AN APPORTIONMENT CLAIM?  YES  NO IF YES, ANSWER THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: \_\_\_\_\_

OTHER INSURER(S) INVOLVED: \_\_\_\_\_

EXPLAIN THE TERMS OF THE APPORTIONMENT: \_\_\_\_\_

28. COMMENTS:

  
  
  
  

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

**AUGUSTA**  
442 CIVIC CTR. DRIVE, 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

29. PREPARER NAME (TYPE OR PRINT): \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

30. TELEPHONE NUMBER: (       )

TOLL-FREE NUMBER: (       )

31. DATE MAILED: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY