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

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

MEMORANDUM OF PAYMENT

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 ☐ SPECIFIC LOSS: _____ WEEKS ☐ SALARY CONTINUATION ☐ OTHER (EXPLAIN): _____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY DATE EMPLOYER NOTIFIED OF INCAPACITY: _____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY

25. AVERAGE WEEKLY WAGE:	26. BENEFIT TYPE:	27. NET CHECK AMOUNT (AFTER OFFSETS):
$ _____	☐ TOTAL INCAPACITY (§212) ☐ PARTIAL INCAPACITY (§213) ☐ FATAL (§215/§355 (14) (F))	☐ FIXED $ _____ THIS AMOUNT IS EQUAL TO THE EMPLOYEE'S WEEKLY COMPENSATION RATE MINUS OFFSETS REPORTED IN BOX 27A. ☐ 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 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	56 NORTHPORT DR, STE 201 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

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