

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

1. REVISION DATE:
MM / DD / YYYY

2. WCB FILE NUMBER (REQUIRED):

MODIFICATION OF COMPENSATION

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
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7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER: ()
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12. DATE OF INJURY: MM / DD / YYYY	13. SPECIFIC INJURY OR ILLNESS:	14. BODY PART(S) AFFECTED:		
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EMPLOYER/INSURER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:		
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18. INSURER NAME:	19. INSURER MAILING ADDRESS AND PHONE NUMBER:			
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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):

<input type="checkbox"/> AGREEMENT OF THE PARTIES/BOARD DECISION (RULES CH.8, §12) \$_____	<input type="checkbox"/> INCREASED EARNINGS WITH SAME EMPLOYER (\$205(9)(A)) \$_____
<input type="checkbox"/> ADJUSTED WAGE/RATE (RULES CH.1, §5(2)(C)) \$_____	<input type="checkbox"/> MAX RATE INCREASE (\$211) \$_____
<input type="checkbox"/> APPORTIONMENT (\$354) \$_____	<input type="checkbox"/> PAID TIME OFF (\$221(3)(A)(2)) \$_____
<input type="checkbox"/> CHANGE IN PAYMENT TYPE \$_____	<input type="checkbox"/> RTW WITH SAME EMPLOYER, MODIFIED DUTY (\$205(9)(A)) \$_____
<input type="checkbox"/> COST OF LIVING ADJUSTMENT \$_____	<input type="checkbox"/> SOCIAL SECURITY RETIREMENT (\$221(3)(A)(1)) \$_____
<input type="checkbox"/> DECREASED EARNINGS WITH SAME EMPLOYER (\$205(9)(A)) \$_____	<input type="checkbox"/> THIRD PARTY LIABILITY (\$107) \$_____
<input type="checkbox"/> DISABILITY INSURANCE (\$221(3)(A)(2)-(3)) \$_____	<input type="checkbox"/> UNEMPLOYMENT COMPENSATION (\$220) \$_____
<input type="checkbox"/> EMPLOYER FUNDED PENSION (\$221(3)(A)(5)) \$_____	<input type="checkbox"/> WAGE CONTINUATION PLAN (\$221(3)(A)(2)) \$_____
<input type="checkbox"/> FRINGE BENEFITS (\$102(4)(H)) \$_____	<input type="checkbox"/> OTHER (EXPLAIN): _____ \$_____

21. PAYMENT TYPE:	22. BENEFIT TYPE:
<input type="checkbox"/> WEEKLY COMPENSATION	<input type="checkbox"/> TOTAL INCAPACITY (\$212)
<input type="checkbox"/> SPECIFIC LOSS _____ WEEKS	<input type="checkbox"/> PARTIAL INCAPACITY (\$213)
<input type="checkbox"/> SALARY CONTINUATION	<input type="checkbox"/> FATAL (\$215/\$355(14)(F))
<input type="checkbox"/> OTHER (EXPLAIN): _____	

23. OLD WEEKLY CHECK AMOUNT:	24. NEW WEEKLY CHECK AMOUNT:	25. EFFECTIVE DATE OF MODIFICATION: MM / DD / YYYY
<input type="checkbox"/> FIXED \$ _____	<input type="checkbox"/> FIXED \$ _____	
<input type="checkbox"/> VARYING	<input type="checkbox"/> VARYING	

26. COMMENTS:

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

AUGUSTA 442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	BANGOR 396 GRIFFIN RD, STE 105 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	PORTLAND 56 NORTHPORT DR, STE 201 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858
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27. PREPARER'S FULL NAME (REQUIRED):	28. TELEPHONE NUMBER (REQUIRED): ()	29. DATE SENT TO WCB: MM / DD / YYYY
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER: ()	