

WAGE STATEMENT

1. REVISION DATE:		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. EMPLOYEE MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. PHONE NUMBER:
12. DATE OF INJURY:	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

For assistance with your claim, visit: <https://www.maine.gov/wcb/Departments/crs/regionaloffices.html> or call 888-801-9087.

20. Does employee work concurrently? Yes No If yes, a Wage Statement must be submitted for each employer.
 Names: (1) _____ (2) _____ (3) _____

21. Method of Calculation: 102(4)(A) – Salaried 102(4)(C) – Seasonal Worker
 102(4)(B) – Varying Wages 102(4)(D) – Other*

* You must submit a minimum of 2 comparable Wage Statements with this filing and provide a detailed explanation of the calculation.

22. LIST GROSS EARNINGS FOR EACH WEEK:

WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS
1			19			37		
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			23. TOTAL EARNINGS \$		
18			36			24. GROSS AVERAGE WEEKLY WAGE \$		

COMMENTS:

25. PREPARER'S FULL NAME (REQUIRED):	26. TELEPHONE NUMBER (REQUIRED):	27. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY: