

1. REVISION DATE:	<b>MEMORANDUM OF ONE-TIME PAYMENT</b>	2. WCB FILE NUMBER (REQUIRED):
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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. PAYMENT IS MADE FOR THE FOLLOWING REASON (CHOOSE ONE):**

<input type="checkbox"/> Administrative Law Judge (ALJ) decree (closed-end period) <input type="checkbox"/> Consent Decree (closed-end period) <input type="checkbox"/> Death No Dependents (payment to the State) <input type="checkbox"/> Disfigurement (Pre-1993 claims only) Body Part: <input type="checkbox"/> Mandatory Payment Per Rule 1.1 <input type="checkbox"/> Mediation Agreement (closed-end period) <input type="checkbox"/> Occupational Loss of Hearing <input type="checkbox"/> Permanent Impairment (pre-1993 claims only) Body Part:	Date of Decree Date Signed By ALJ: Date of Death: Weeks: Date NOC Filed: Date of Mediation: Weeks: Weeks:
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	PAYMENT FROM	PAYMENT THROUGH	BENEFIT TYPE	WEEKLY NET AMOUNT	AMOUNT PAID
1			<input type="checkbox"/> TOTAL INCAPACITY (§212) <input type="checkbox"/> PARTIAL INCAPACITY (§213) <input type="checkbox"/> FATAL (§215/§355 (14) (F))	<input type="checkbox"/> FIXED RATE \$ <input type="checkbox"/> VARYING RATE	\$
2			<input type="checkbox"/> TOTAL INCAPACITY (§212) <input type="checkbox"/> PARTIAL INCAPACITY (§213) <input type="checkbox"/> FATAL (§215/§355 (14) (F))	<input type="checkbox"/> FIXED RATE \$ <input type="checkbox"/> VARYING RATE	\$
3			<input type="checkbox"/> TOTAL INCAPACITY (§212) <input type="checkbox"/> PARTIAL INCAPACITY (§213) <input type="checkbox"/> FATAL (§215/§355 (14) (F))	<input type="checkbox"/> FIXED RATE \$ <input type="checkbox"/> VARYING RATE	\$
4			<input type="checkbox"/> TOTAL INCAPACITY (§212) <input type="checkbox"/> PARTIAL INCAPACITY (§213) <input type="checkbox"/> FATAL (§215/§355 (14) (F))	<input type="checkbox"/> FIXED RATE \$ <input type="checkbox"/> VARYING RATE	\$
5			<input type="checkbox"/> TOTAL INCAPACITY (§212) <input type="checkbox"/> PARTIAL INCAPACITY (§213) <input type="checkbox"/> FATAL (§215/§355 (14) (F))	<input type="checkbox"/> FIXED RATE \$ <input type="checkbox"/> VARYING RATE	\$

21. Total Amount Paid \$	22. Date of Payment:
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Terms/Comments:

23. PREPARER'S FULL NAME (REQUIRED):	24. TELEPHONE NUMBER (REQUIRED):	25. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY: