1. REVISION DATE:	**DISCONTINUANCE OF COMPENSATION**	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

Your weekly compensation benefits are being discontinued.

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

20. REASON FOR DISCONTINUANCE (CHOOSE ONE):

- ☐ RETURNED TO WORK FOR SAME EMPLOYER REGULAR / FULL DUTY MEDICAL RELEASE (RULES CH. 8, §11(2))
- ☐ RETURNED TO WORK FOR SAME EMPLOYER EARNING AT / ABOVE AVERAGE WEEKLY WAGE (§205(9)(A))
- ☐ AGREEMENT OF THE PARTIES / BOARD DECISION (RULES, CH. 8 §12)
- ☐ LUMP SUM SETTLEMENT
- ☐ NOC FILED WITHIN 45 DAYS PURSUANT TO §205(2)(C)
- ☐ OTHER (EXPLAIN):_____

21. PERIOD OF INCAPACITY FROM DATE: THROUGH DATE:	22. WEEKLY NET AMOUNT FROM MEMORANDUM OF PAYMENT OR MOST RECENT MODIFICATION: $
23. TOTAL WEEKLY COMPENSATION PAID FOR THE PERIOD OF INCAPACITY IN BOX 21: $	24. DATE OF FINAL PAYMENT:

COMMENTS:

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

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.