1. REVISION DATE):	**MODIFICATION 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 (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

Your workers' compensation weekly compensation payments have been modified.

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

20. Reasons for Modification (check all that apply):

☐ Adjusted Wage/Rate (Rules Ch.1, §5(2)(C))	$	☐ Increased Earnings Same ER (§205(9)(A))	$
☐ Agreement/Board Decision (Rules Ch.8, §12)	$	☐ Max Rate Increase (§211)	$
☐ Apportionment (§354)	$	☐ Paid Time Off (§221(3)(A)(2))	$
☐ Change in Benefit Type		☐ RTW Same ER, Modified Duty (§205(9)(A))	$
☐ Change in Payment Type	$	☐ Social Security Retirement (§221(3)(A)(1))	$
☐ Cost of Living Adjustment	$	☐ Third Party Liability (§107)	$
☐ Decreased Earnings Same ER (§205(9)(A))	$	☐ Unemployment Compensation (§220)	$
☐ Disability Insurance (§221(3)(A)(2)-(3))	$	☐ Wage Continuation Plan (§221(3)(A)(2))	$
☐ Employer Funded Pension (§221(3)(A)(5))	$	☐ Other (Explain):	$
☐ Fringe Benefits (§102(4)(H))	$	☐ Other (Explain):	$

21. Payment Type:

☐ Weekly Compensation

☐ Specific Loss Body Part(s): Weeks:

☐ Salary Continuation (ER paying at/above AWW; insurer not paying any benefits at this time)

☐ Other (Explain):

22. Benefit type as of Effective Date:	23. Old Weekly Net Amount:	24. New Weekly Net Amount:	25. Effective Date of Modification:
☐ Total Incapacity (§212) ☐ Partial Incapacity (§213) ☐ Fatal (§215/§355(14)(F))	☐ Fixed $ ☐ Varying	☐ Fixed* $ *Salary Continuation amount or rate minus offsets, if any ☐ Varying	

Comments:

26. PREPARER'S FULL NAME (REQUIRED):	27. TELEPHONE NUMBER (REQUIRED):	28. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	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.