1.REVISION DATE:	**STATEMENT OF COMPENSATION PAID**	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 PARTS (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. REASON FOR REPORT (CHOOSE ONE):

☐ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)

☐ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

PAYMENT SUMMARY

21. LIST CUMULATIVE TOTALS (DO NOT INCLUDE PENALTY AMOUNTS):

MEDICAL TREATMENT	$	**DEATH BENEFIT/FUNERAL EXPENSE** (NOT TO EXCEED $7,000)	$
WEEKLY COMPENSATION	$	**EMPLOYEE-RELATED LEGAL EXPENSE**	$
PERMANENT IMPAIRMENT (PRE1993 CLAIMS ONLY)	$	**EMPLOYER-RELATED LEGAL EXPENSE**	$
EMPLOYMENT REHABILITATION	$	**INTEREST AND OTHER PAYMENTS**	$
LUMP SUM SETTLEMENT	$		
	TOTAL AMOUNT PAID (DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES.)		$

COMMENTS:

22. PREPARER'S FULL NAME (REQUIRED):	23. TELEPHONE NUMBER (REQUIRED):	24. 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.