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 (MM/DD/YYYY):	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. TYPE: ☐ **INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)** ☐ **FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)**

21. LIST CUMULATIVE TOTALS:

MEDICAL TREATMENT (TREATMENT DOES NOT INCLUDE EXPENSES RELATED TO MANAGED CARE SERVICES SUCH AS UTILIZATION REVIEW, CASE MANAGEMENT, AND BILL REVIEW, OR TO EXAMS PERFORMED PURSUANT TO §§ 207 AND 312.)	$	**DEATH BENEFIT/FUNERAL EXPENSE** (NOT TO EXCEED $7,000)	$
WEEKLY COMPENSATION (WHEN FILING THIS FORM AS A FINAL, THIS AMOUNT MUST MATCH THE SUM OF THE AMOUNT PAID ON ALL PAYMENT FORMS)	$	**EMPLOYEE-RELATED LEGAL EXPENSE**	$
		EMPLOYER-RELATED LEGAL EXPENSE	$
PERMANENT IMPAIRMENT (PRE-1993 CLAIMS ONLY)	$	**INTEREST AND OTHER PAYMENTS** (OTHER PAYMENTS INCLUDE BUT ARE NOT LIMITED TO: EXPERT WITNESS FEES, COURT REPORTER FEES, PRIVATE INVESTIGATOR FEES, MEDICAL AND OTHER TRAVEL COSTS, COSTS RELATED TO MANAGED CARE SERVICES SUCH AS UTILIZATION REVIEW, CASE MANAGEMENT, AND BILL REVIEW, AND EXAMS PERFORMED PURSUANT TO §§ 207 AND 312)	$
EMPLOYMENT REHABILITATION	$		
LUMP SUM SETTLEMENT (THIS AMOUNT MUST MATCH THE APPROVED AMOUNT ON FORM WCB-10)	$		

TOTAL AMOUNT PAID (DO NOT INCLUDE ANY PENALTY AMOUNTS, AMOUNTS PAID TO THE "LEAD" CARRIER ON APPORTIONMENT CASES, OR AMOUNTS PAID BY THE EMPLOYER. 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.