

**PETITION FOR EXTENSION OF BENEFITS
PURSUANT TO 39-A M.R.S.A. §213(1)**

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0027

EMPLOYEE

EMPLOYER

NAME: _____] NAME: _____
STREET/P.O. BOX: _____] STREET/P.O. BOX: _____
CITY, STATE ZIP: _____] CITY, STATE ZIP: _____
TELEPHONE NUMBER: _____] **INSURANCE COMPANY**
EMPLOYEE SOCIAL SECURITY #: _____] NAME: _____
BOARD FILE NUMBER (If known): _____] STREET/P.O. BOX: _____
] CITY, STATE ZIP: _____

1. On _____, _____ experienced
MONTH, DAY, YEAR EMPLOYEE NAME
a work-related injury while working for _____
EMPLOYER NAME
2. Compensation for \$ _____ per week is being paid for _____
PARTIAL / TOTAL (Select one)
incapacity.
3. Compensation benefits were discontinued as of _____
MONTH DAY YEAR

WHEREFORE, the employee asks that the Board, after considering the evidence at hearing, finds that the employee is suffering extreme financial hardship due to an inability to return to gainful employment, and Order the employer to reinstate benefits to the employee.

MONTH DAY YEAR

SIGNATURE OF EMPLOYEE

NAME OF EMPLOYEE'S ATTORNEY/ADVOCATE (If any)

STREET / P.O. BOX

CITY, STATE ZIP

FILING INSTRUCTIONS:

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy by certified mail, return receipt requested to the insurance company.
3. Mail one (1) copy by certified mail, return receipt requested to the employer.
4. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES OR ACTIVITIES. THIS MATERIAL CAN BE MADE AVAILABLE IN ALTERNATE FORMATS BY CONTACTING YOUR DEPARTMENT'S ADA COORDINATOR.