

**PETITION FOR FORFEITURE  
PURSUANT TO 39-A §324(2)**

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

**PETITIONER - EMPLOYEE**

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: \_\_\_\_\_  
(last four digits required)  
BOARD FILE NUMBER: \_\_\_\_\_

**RESPONDENT - EMPLOYER**

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_

**RESPONDENT - INSURER**

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_

**NOTICE**

A party is not required to file a written response to this petition. 39-A M.R.S.A. §307(3).

1. On \_\_\_\_\_, \_\_\_\_\_ sustained a work-related injury while working for \_\_\_\_\_.  
MONTH DAY YEAR EMPLOYEE NAME EMPLOYER NAME
2. On \_\_\_\_\_, the Workers' Compensation Board: **[CHECK ONE]**  
MONTH DAY YEAR  
 Issued a decision or order granting a petition and ordering payment of compensation in the amount of \$ \_\_\_\_\_ for the period \_\_\_\_\_ to \_\_\_\_\_; OR  
AMOUNT MONTH DAY YEAR MONTH DAY YEAR  
 Approved an agreement for the payment of compensation in the amount of \$ \_\_\_\_\_ for the period \_\_\_\_\_ to \_\_\_\_\_.  
AMOUNT MONTH DAY YEAR MONTH DAY YEAR
3. The respondent has failed to comply with the Board order or decision or approved agreement by not paying the compensation ordered or agreed to be paid until \_\_\_\_\_.  
MONTH DAY YEAR

**THEREFORE**, I request such penalties and attorney's fees as I may be entitled pursuant to Title 39-A §324(2).

DATED: \_\_\_\_\_  
MONTH DAY YEAR

\_\_\_\_\_  
SIGNATURE OF PETITIONER

**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 each other party named in the petition.
3. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

\_\_\_\_\_  
NAME OF PETITIONER'S ATTORNEY OR ADVOCATE (IF ANY)

\_\_\_\_\_  
STREET/P.O. BOX

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
TELEPHONE NUMBER

The State of Maine provides equal opportunity in employment and programs. 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: (888) 801-9087 or TTY Maine Relay 711. WCB-281 (eff. 1/1/13)