

# MEMORANDUM OF PAYMENT

1. REVISION DATE: \_\_\_\_\_  
MM / DD / YYYY

2. WCB FILE NUMBER  
(if known): \_\_\_\_\_

### EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits): XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:	9. STATE:	10. ZIP:	11. HOME PHONE NUMBER: (       )
12. DATE OF INJURY: MM / DD / YYYY	13. SPECIFIC INJURY OR ILLNESS:		14. BODY PARTS (S) AFFECTED:	

### EMPLOYER

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

20. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS WORKERS' COMPENSATION FORM UPON PAYMENT OF A LOST TIME WORK-RELATED INJURY. PAYMENT IS MADE FOR THE FOLLOWING REASON:

- A.  YOUR CLAIM IS ACCEPTED.
- B.  THIS IS A VOLUNTARY PAYMENT PENDING INVESTIGATION.
- C.  THIS IS A MANDATORY PAYMENT PURSUANT TO RULE 1.1. AMOUNT PAID \$ \_\_\_\_\_. PERIOD COVERED BY MANDATORY PAYMENT:  
FROM (DATE CLAIM MADE) \_\_\_\_/\_\_\_\_/\_\_\_\_ THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

21. TYPE OF PAYMENT: A. <input type="checkbox"/> WEEKLY COMPENSATION B. <input type="checkbox"/> SPECIFIC LOSS: _____ WEEKS C. <input type="checkbox"/> OTHER (EXPLAIN): _____	22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET:  ____/____/____ MM DD YYYY
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23. DATE OF INCAPACITY: ____/____/____ MM DD YYYY  DATE EMPLOYER NOTIFIED OF INCAPACITY: ____/____/____ MM DD YYYY	24. DATE CHECK MAILED: ____/____/____ MM DD YYYY	25. AVERAGE WEEKLY WAGE: \$ _____	26. CURRENT WEEKLY COMPENSATION RATE: <input type="checkbox"/> TOTAL <input type="checkbox"/> PARTIAL  \$ _____ <small>(IF VARYING RATES ARE BEING PAID, ENTER THE WORD "VARYING")</small>
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27. IS THIS AN APPORTIONMENT CLAIM?  YES  NO IF YES, ANSWER THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: \_\_\_\_\_

OTHER INSURER(S) INVOLVED: \_\_\_\_\_

EXPLAIN THE TERMS OF THE APPORTIONMENT: \_\_\_\_\_

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28. COMMENTS:

  
  
  
  
  
  
  
  
  
  

### ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

<b>AUGUSTA</b> 24 STONE ST, STE 102 AUGUSTA, ME 04330-5220 (207) 287-2308 1-800-400-6854	<b>BANGOR</b> 106 HOGAN RD BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	<b>CARIBOU</b> ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	<b>LEWISTON</b> 36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	<b>PORTLAND</b> 1037 FOREST AVE, STE 11 PORTLAND, ME 04103-3382 (207) 822-0840 1-800-400-6858
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29. PREPARER NAME (TYPE OR PRINT):  E-MAIL ADDRESS:	30. TELEPHONE NUMBER: (       )  TOLL-FREE NUMBER: (       )	31. DATE MAILED:  ____/____/____ MM DD YYYY
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