

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:	
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/TPA NAME:		19. INSURER/TPA MAILING ADDRESS:			

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 BECAUSE A NOTICE OF CONTROVERSY WAS NOT TIMELY FILED PURSUANT TO RULE 1.1.
PERIOD COVERED BY MANDATORY PAYMENT: FROM (DATE) ____/____/____ THROUGH (DATE) ____/____/____ AMOUNT PAID \$ _____
MM DD YYYY MM DD YYYY

21. TYPE OF PAYMENT:

A. WEEKLY COMPENSATION

B. SPECIFIC LOSS _____ WEEKS AMOUNT PAID \$ _____

C. PERMANENT IMPAIRMENT AMOUNT PAID \$ _____

D. OTHER (EXPLAIN) _____

22 A. IS THERE ANY INDICATION THAT THE INJURY IS PERMANENT? YES NO

B. IF THE ANSWER IS YES, WHAT IS THE PERMANENT IMPAIRMENT RATING? % NOT YET AVAILABLE

23. DATE 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 \$	
DATE EMPLOYER NOTIFIED: ____/____/____ MM / DD / YYYY							

27. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? YES NO
IF YES, GIVE NAME: _____

28. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD IS MET:
____/____/____
MM / DD / YYYY

29. IS THIS AN APPORTIONMENT CLAIM? YES NO IF YES, ANSWER THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: _____

OTHER CARRIER(S) INVOLVED: _____

WHO IS THE "LEAD" CARRIER? _____

EXPLAIN THE TERMS OF THE APPORTIONMENT: _____

30. COMMENTS:

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

AUGUSTA
24 STONE ST, STE 2
AUGUSTA, ME
04330-5220
(207)287-2308
1-800-400-6854
TTY (877) 832-5525

BANGOR
106 HOGAN ROAD
BANGOR, ME
04401-5638
(207)941-4550
1-800-400-6856

CARIBOU
ONE VAUGHN PLACE
43HATCH DR, STE 110
LEWISTON, ME 04240
(207)498-6428
1-800-400-6855

LEWISTON
36 MOLLISON WAY
LEWISTON, ME
04240-7777
(207)753-7700
1-800-400-6857

PORTLAND
62 ELM ST.
PORTLAND, ME
04101-3061
(207)822-0840
1-800-400-6858

31. CLAIM HANDLER NAME (TYPE OR PRINT): E-MAIL ADDRESS: _____		32. TELEPHONE NUMBER: () TOLL FREE NUMBER: ()		33. DATE SENT TO WCB: ____/____/____ MM / DD / YYYY	
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WCB-3 (10/98) 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 FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525.