

1. REVISION DATE:		<b>STATEMENT OF COMPENSATION PAID</b>		2. WCB FILE NUMBER (REQUIRED):	
<b>EMPLOYEE</b>					
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:		13. SPECIFIC INJURY OR ILLNESS:			14. BODY PARTS (S) AFFECTED:
<b>EMPLOYER/INSURER</b>					
15. INSURER FILE NUMBER:		16. EMPLOYER NAME:		17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	
18. INSURER NAME:		19. INSURER MAILING ADDRESS AND PHONE NUMBER:			
<b>NOTICE TO EMPLOYEE</b>					
For assistance with your claim, visit: <a href="https://www.maine.gov/wcb/Departments/crs/regionaloffices.html">https://www.maine.gov/wcb/Departments/crs/regionaloffices.html</a> or call 888-801-9087.					
<b>20. REASON FOR REPORT (CHOOSE ONE):</b>					
<input type="checkbox"/> INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)		<input type="checkbox"/> FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)			
<b>PAYMENT SUMMARY</b>					
<b>21. LIST CUMULATIVE TOTALS (DO NOT INCLUDE PENALTY AMOUNTS):</b>					
<b>MEDICAL TREATMENT</b>		\$	<b>DEATH BENEFIT/FUNERAL EXPENSE</b>		\$
			(NOT TO EXCEED \$7,000)		
<b>WEEKLY COMPENSATION</b>		\$	<b>EMPLOYEE-RELATED LEGAL EXPENSE</b>		\$
<b>PERMANENT IMPAIRMENT</b> (PRE 1993 CLAIMS ONLY)		\$	<b>EMPLOYER-RELATED LEGAL EXPENSE</b>		\$
<b>EMPLOYMENT REHABILITATION</b>		\$	<b>INTEREST AND OTHER PAYMENTS</b>		\$
<b>LUMP SUM SETTLEMENT</b>		\$			
<b>TOTAL AMOUNT PAID</b> (DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES.)					\$
<b>COMMENTS:</b>					
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:	