1. REVISION DATE:	**FRINGE BENEFITS WORKSHEET**	2. WCB FILE NUMBER (REQUIRED):

EMPLOYEE

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:	

EMPLOYER/INSURER

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

For assistance with your claim, visit: https://www.maine.gov/wcb/Departments/crs/regionaloffices.html or call 888-801-9087.

Form Instructions:

(1) For each Fringe Benefit listed on the form, indicate if the benefit is provided.
- If the benefit is provided at no cost to the employer, "No" may be selected.

(2) For each Fringe Benefit provided, indicate if the benefit continues while the employee is out of work.

(3) For each Fringe Benefit that does not continue, provide a date the benefit ends and the weekly cost of the benefit.
- If the date is unknown, "TBD" or "Unknown" are acceptable.
- A percentage may be submitted in lieu of a dollar amount for a 401K fringe benefit.

20. Fringe Benefit	Is the Fringe Benefit provided?	Does the benefit continue while the employee is out of work?	Date Benefit Ends	Weekly Cost to Employer
Health Benefits (incl. insurance)	Yes ☐ No ☐	Yes ☐ No ☐		
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐		
Disability Insurance (inc. short and long term)	Yes ☐ No ☐	Yes ☐ No ☐		
401K	Yes ☐ No ☐	Yes ☐ No ☐		
Life Insurance	Yes ☐ No ☐	Yes ☐ No ☐		
Education/Training	Yes ☐ No ☐	Yes ☐ No ☐		
Pension	Yes ☐ No ☐	Yes ☐ No ☐		
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		

21. TYPE OR PRINT PREPARER NAME (REQUIRED):	22. TELEPHONE NUMBER (REQUIRED):	23. DATE SENT TO WCB :
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY:

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.