

1. REVISION DATE:	DISCONTINUANCE OF COMPENSATION	2. WCB FILE NUMBER (REQUIRED):
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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 PART(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

Your weekly compensation benefits are being discontinued.

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

20. REASON FOR DISCONTINUANCE (CHOOSE ONE):	
RETURNED TO WORK FOR SAME EMPLOYER REGULAR / FULL DUTY MEDICAL RELEASE (RULES CH. 8, §11(2))	RETURNED TO WORK FOR SAME EMPLOYER EARNING AT / ABOVE AVERAGE WEEKLY WAGE (§205(9)(A))
AGREEMENT OF THE PARTIES / BOARD DECISION (RULES, CH. 8 §12)	LUMP SUM SETTLEMENT
NOC FILED WITHIN 45 DAYS PURSUANT TO §205(2)(C)	OTHER (EXPLAIN): _____

21. PERIOD OF INCAPACITY	22. WEEKLY NET AMOUNT FROM MEMORANDUM OF PAYMENT OR MOST RECENT MODIFICATION:
FROM DATE:	\$
THROUGH DATE:	

23. TOTAL WEEKLY COMPENSATION PAID FOR THE PERIOD OF INCAPACITY IN BOX 21:	24. DATE OF FINAL PAYMENT:
\$	

COMMENTS:

25. PREPARER'S FULL NAME (REQUIRED):	26. TELEPHONE NUMBER (REQUIRED):	27. DATE SENT TO WCB:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	WCB USE ONLY: