AmTrust North America
An AmTrust Financial Company

Maine
Worker's Compensation
Claim Kit

(p) 888.239.3909 • (f) 678.258.8399 • www.amtrustfinancial.com

AmTrust North America
An AmTrust Financial Company

Table of Contents

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EASY ONLINE CLAIMS REPORTING INSTRUCTIONS

By logging into AmTrust's web portal, policyholders can access a wide variety of account information including the ability to report injuries online. The following instructions will help get you started.

First Time Portal Access:

1. Go to www.amtrustnorthamerica.com
2. In the upper right corner of the home page, click "LOGIN"
3. In the subsequent AmTrust *Online* drop-down box, click the word "**Register**"
4. On the following screen, enter your policy number, zip code and the security code that appears on that screen and click "**Enter**" at the bottom right of the screen
5. Enter your email address, user name and password to complete the registration process
6. After completing the registration process, go back to www.amtrustnorthamerica.com and log in

Reporting of New Injuries:

1. Go to www.amtrustnorthamerica.com
2. Log in to "AmTrust ***Online***"
3. Click the "**Claims**" icon in the upper middle of your screen to view the screen that lists your policies
4. Click "**View**" next to the policy for which you wish to enter a claim. This brings you to the policy detail screen
5. Click on "**First Reports**" in the upper left corner
6. On the next screen, click "**Add**" to view the "**New First Report of Injury**" screen
7. Click "**Use WebForm**." This brings you to the screen where you will enter all of the detailed information about the injury/injured worker
8. When finished entering all of the data, click "**Submit**" and this report will channel into our intake center to be set up and assigned to a claims adjuster
9. Return to the "**First Reports"** screen and you will see the claim number for the report entered
10. When finished, click on "**Return to Listing**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

AmTrust North America
An AmTrust Financial Company

Helpful Hints:

- "**Time Employee Began Work**" and "**Time of Occurrence**" must be entered in military time
- Enter the hours in the first box and the minutes in the second box
- All dates must be entered as two-digit day, two-digit month and four-digit year, i.e.: XX/XX/XXXX
- For PEOs, in the "**Location Address**" box, please include the PEO client name and address of the applicable PEO client location. If there is a location code/number, specify in the "**Location #**" box
- If during the entry of a claim you must exit the application, first click on "S**ave as Draft**" and you may return to it later by going back into the "**First Reports"** screen and clicking on "**In Progress**"

For ID/Password issues or if you receive error messages while using this application, please contact our help desk at help.desk@amtrustgroup.com or call 866.427.6150. Please be sure to specify that you are an AmTrust policyholder and provide your AmTrust Online ID.

Thank you for your attention to this matter.

Sincerely,

AmTrust North
America Claims
Department

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR IJ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☒ YES ☒ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS: P.O. BOX 6935	23. CITY: CLEVELAND	24. STATE: OH	25. ZIP: 44101	26. TELEPHONE NUMBER: (888) 239-3909

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER:	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:	55. HEALTH CARE PROVICER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY

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 Maine Relay 711.

1. REVISION DATE: _____/_____/_____ MM DD YYYY

MEMORANDUM OF PAYMENT

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/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

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 WITHOUT PREJUDICE.

C. ☐ THIS IS A MANDATORY PAYMENT PURSUANT TO RULE 1.1. AMOUNT PAID $ _____. PERIOD COVERED BY MANDATORY PAYMENT:

FROM (DATE CLAIM MADE) _____/_____/_____ MM DD YYYY THROUGH (DATE NOTICE OF CONTROVERSY FILED AND BENEFITS PAID) _____/_____/_____ MM DD YYYY

21. TYPE OF PAYMENT:	22. FIRST DAY OF COMPENSABILITY AFTER WAITING PERIOD WAS MET:	23. DATE OF INCAPACITY:	24. DATE CHECK MAILED:	25. AVERAGE WEEKLY WAGE:
A. ☐ WEEKLY COMPENSATION B. ☐ SPECIFIC LOSS: _____ WEEKS C. ☐ SALARY CONTINUATION D. ☐ OTHER (EXPLAIN):_____	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY DATE EMPLOYER NOTIFIED OF INCAPACITY: _____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY	$ _____

26. WEEKLY CHECK AMOUNT (NET):

$ _____

(IF VARYING RATES ARE BEING PAID, ENTER THE WORD "VARYING")

BENEFIT TYPE:

A. ☐ TOTAL INCAPACITY (§212)

B. ☐ PARTIAL INCAPACITY (§213)

C. ☐ FATAL (§215/§355 (14) (F))

27. WEEKLY CHECK REDUCED FOR:

A. ☐	3rd PARTY LIABILITY (§107)	$_____
B. ☐	EARNINGS ((§213(1))	$_____
C. ☐	UNEMPLOYMENT COMPENSATION (§220)	$_____
D. ☐	SOCIAL SECURITY RETIREMENT (§221(3)(A)(1))	$_____
E. ☐	PAID TIME OFF (§221(3)(A)(2))	$_____
F. ☐	WAGE CONTINUATION PLAN (§221(3)(A)(2))	$_____
G. ☐	DISABILITY INSURANCE (§221(3)(A)(3))	$_____
H. ☐	EMPLOYER FUNDED PENSION (§ 221(3)(A)(5))	$_____
I. ☐	APPORTIONMENT (§ 354)	$_____
J. ☐	OTHER:_____	$_____
K. ☐	NOT APPLICABLE	

27a. IF THIS IS AN APPORTIONMENT CLAIM, PLEASE COMPLETE THE FOLLOWING:

OTHER DATE(S) OF INJURY INVOLVED: _____

OTHER INSURER(S) INVOLVED: _____

EXPLAIN THE TERMS OF THE APPORTIONMENT:_____

28. COMMENTS:

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
442 CIVIC CTR. DRIVE, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

29. PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	30. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	31. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. 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: 1-888-801-9087 or TTY Maine Relay 711.

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**CONSENT BETWEEN EMPLOYER AND EMPLOYEE**	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/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:	

18. TERMS OF CONSENT:			
18A. DATE OF INCAPACITY:	18B. AVERAGE WEEKLY WAGE:	18C. CURRENT WEEKLY COMPENSATION RATE: TOTAL ☐ PARTIAL ☐	18D. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S): YES ☐ NO ☐
18E. NEW COMPENSATION RATE:	18F. EFFECTIVE DATE OF REDUCTION:	18G. EFFECTIVE DATE OF DISCONTINUANCE:	18H. AMOUNT PAID:

NOTICE TO EMPLOYEE (Please read and initial)

19.
BEFORE YOU SIGN THIS FORM, YOU SHALL CALL THE WORKERS' COMPENSATION BOARD'S OFFICES TO FIND OUT WHAT RIGHTS YOU HAVE IF YOU SIGN THIS FORM. A LIST OF THE BOARD'S REGIONAL OFFICES IS SHOWN AT THE BOTTOM OF THIS PAGE.

EMPLOYEE INITIALS: _____

NOTICE TO EMPLOYER

THIS FORM SHALL NOT BE USED FOR CASES WHEN AN ORDER, AWARD OF COMPENSATION OR A COMPENSATION SCHEME WAS ENTERED UNDER SECTION 205 (9)(B)(2).

CONSENT

20.
WE AGREE TO THE TERMS LISTED IN BOX 18 ABOVE. WE UNDERSTAND THAT THIS IS NOT A FINAL SETTLEMENT. SIGNING THIS CONSENT FORM CREATES A PAYMENT WITHOUT PREJUDICE, DOES NOT CREATE A PAYMENT SCHEME, AND DOES NOT PREVENT EITHER PARTY FROM REOPENING THE CLAIM WITHIN CERTAIN TIME LIMITS. THIS FORM MUST BE SIGNED BY THE EMPLOYEE, EMPLOYEE'S ATTORNEY OR WORKER ADVOCATE IF ANY, AND THE EMPLOYER/INSURER OR BY A DULY AUTHORIZED REPRESENTATIVE.

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____
EMPLOYEE 'S AUTHORIZED REPRESENTATIVE SIGNATURE (IF APPLICABLE) DATE

_____ _____
EMPLOYER/INSURER OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE

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

AUGUSTA	**BANGOR**	**CARIBOU**	**LEWISTON**	**PORTLAND**
442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

21. PREPARER NAME AND TITLE (TYPE OR PRINT):	22. TELEPHONE NUMBER:	23. DATE MAILED:

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DISCONTINUANCE OF COMPENSATION

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027**	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/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:	

20. REASON FOR DISCONTINUANCE:

- ☐ RETURNED TO WORK FOR SAME EMPLOYER REGULAR/FULL DUTY MEDICAL RELEASE
- ☐ RETURNED TO WORK FOR SAME EMPLOYER EARNING AT/ABOVE AVERAGE WEEKLY WAGE
- ☐ BOARD DECISION
- ☐ NOC FILED WITHIN 45 DAYS PURSUANT TO §205(2)(2)(C)
- ☐ OTHER (EXPLAIN) _____

21. PERIOD OF INCAPACITY: FROM (DATE): TO (RETURN DATE):	22. WEEKLY COMPENSATION RATE:	23. AMOUNT PAID:	24. DATE FINAL PAYMENT MAILED:

25. COMMENTS:

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

AUGUSTA	**BANGOR**	**CARIBOU**	**LEWISTON**	**PORTLAND**
442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

26. PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	27. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	28. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. 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: 1-888-801-9087 or TTY Maine Relay 711.
WCB-4D (effective 9/1/2020, revised 3/7/2022)

MODIFICATION OF COMPENSATION

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027**	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/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:	

INCREASE

20. WEEKLY CHECK INCREASED FOR:

- ☐ DECREASED EARNINGS WITH SAME EMPLOYER
- ☐ FRINGE BENEFITS
- ☐ BOARD DECISION
- ☐ MAX RATE INCREASE
- ☐ COST OF LIVING ADJUSTMENT
- ☐ 3rd PARTY LIABILITY (§107)
- ☐ EARNINGS ((§213(1))
- ☐ UNEMPLOYMENT COMPENSATION (§220)
- ☐ SOCIAL SECURITY RETIREMENT (§221(3)(A)(1))
- ☐ PAID TIME OFF (§221(3)(A)(2))
- ☐ WAGE CONTINUATION PLAN (§221(3)(A)(2))
- ☐ DISABILITY INSURANCE (§221(3)(A)(3))
- ☐ EMPLOYER FUNDED PENSION (§ 221(3)(A)(5))
- ☐ APPORTIONMENT (§ 354)
- ☐ OTHER (EXPLAIN): _____

DECREASE

21. WEEKLY CHECK DECREASED FOR:

- ☐ INCREASED EARNINGS WITH SAME EMPLOYER
- ☐ FRINGE BENEFITS
- ☐ BOARD DECISION
- ☐ RETURNED TO WORK FOR SAME EMPLOYER, MODIFIED WORK/DUTY
- ☐ 3rd PARTY LIABILITY (§107)
- ☐ EARNINGS ((§213(1))
- ☐ UNEMPLOYMENT COMPENSATION (§220)
- ☐ SOCIAL SECURITY RETIREMENT (§221(3)(A)(1))
- ☐ PAID TIME OFF (§221(3)(A)(2))
- ☐ WAGE CONTINUATION PLAN (§221(3)(A)(2))
- ☐ DISABILITY INSURANCE (§221(3)(A)(3))
- ☐ EMPLOYER FUNDED PENSION (§ 221(3)(A)(5))
- ☐ APPORTIONMENT (§ 354)
- ☐ OTHER (EXPLAIN): _____

22. OLD COMPENSATION RATE:	23. NEW COMPENSATION RATE:	24. EFFECTIVE DATE OF MODIFICATION:

25. BENEFIT TYPE:

- A. ☐ TOTAL (§212)
- B. ☐ PARTIAL (§213)
- C. ☐ FATAL (§215/§355 (14) (F))

26. COMMENTS:

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

27. PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	28. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	29. DATE MAILED: _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. 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: 1-888-801-9087 or TTY Maine Relay 711.

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

CERTIFICATE AUTHORIZING RELEASE OF UNEMPLOYMENT INFORMATION

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/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:		

PART II (COMPLETED BY EMPLOYEE)

I, _____, understand that the information in my unemployment compensation file(s) is confidential under 26 M.R.S.A. §1082(7), of the Maine Revised Statutes. However, I waive my right to confidentiality and authorize the Department of Labor to obtain and release benefit payment information, pertaining to the benefit year ending ____/____/____, or calendar period from _____ through _____ to the following:

Name: _____

Title: _____

Address: _____

_____

I understand that I may also request a copy of this information be sent to me. A copy of this waiver/consent is acceptable. **The completed form should be faxed directly to Scott Pierz, Department of Labor, Bureau of Unemployment Compensation at 207-287-5908.**

Signature:_____ Date:_____

PART III (COMPLETED BY THE BUREAU OF UNEMPLOYMENT COMPENSATION)

Unemployment benefit payment information sent to the requestor on _____.

Signature:_____ Date:_____

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STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION PURSUANT TO 39-A M.R.S.A. 05(9)(B)(1)**	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/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 WILL BE DISCONTINUED OR REDUCED 21 DAYS FROM THE DATE THIS CERTIFICATE WAS MAILED BASED ON THE ATTACHED INFORMATION. IF YOU DISAGREE WITH THIS ACTION, YOU MAY FILE A PETITION FOR REVIEW AND REQUEST REINSTATEMENT OF YOUR BENEFITS PENDING HEARING, UNDER 39-A M.R.S.A. §205(9)(C). YOUR PETITION AND REQUEST (ON FORM WCB-121) MUST BE MAILED TO THE WORKERS' COMPENSATION BOARD ADDRESS ABOVE.

20. REASON FOR DISCONTINUANCE OR REDUCTION (MUST ATTACH SUPPORTING DOCUMENTATION):

DISCONTINUANCE

21. PERIOD OF INCAPACITY: FROM (DATE): TO (EFFECTIVE DATE OF DISCONTINUANCE):	22. WEEKLY COMPENSATION RATE:	23. COMPENSATION PAID TO DATE OF CERTIFICATE:	24. COMPENSATION TO BE PAID FOR 21 DAY PERIOD:

REDUCTION

25. OLD COMPENSATION RATE:	26. NEW COMPENSATION RATE:	27. EFFECTIVE DATE OF REDUCTION:

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
442 CIVIC CTR DR, STE 225	396 GRIFFIN RD, STE 105	ONE VAUGHN PL	36 MOLLISON WAY	1037 FOREST AVE, STE 11
156 STATE HOUSE STATION	BANGOR, ME	43 HATCH DR, STE 110	LEWISTON, ME	PORTLAND, ME
AUGUSTA, ME 04333-0156	04401-5638	CARIBOU, ME 04736	04240-7777	04103
(207) 287-2308	(207) 941-4550	(207) 498-6428	(207) 753-7700	(207) 822-0840
1-800-400-6854	1-800-400-6856	1-800-400-6855	1-800-400-6857	1-800-400-6858

28. TYPE OR PRINT PREPARER NAME (REQUIRED): E-MAIL ADDRESS (REQUIRED):	29. TELEPHONE NUMBER (REQUIRED): TOLL-FREE NUMBER:	30. DATE MAILED (MUST MATCH POSTMARK): _____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. 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: 1-888-801-9087 or TTY Maine Relay 711.

WCB-8 (eff. 1/1/13, rev. 3/24/22)

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

NOTICE OF CONTROVERSY
THIS IS A DENIAL OF YOUR BENEFITS

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/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:	

20. **NOTICE TO EMPLOYEE**

YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW.

21a. **FULL DENIAL REASON**	21b. **PARTIAL DENIAL REASON**
	22a. DATE OF INITIAL INCAPACITY ____/____/____ CURRENT DATE OF INCAPACITY ____/_____/_____
FULL DENIAL EFFECTIVE DATE _____/_____/_____	22b. DATE EMPLOYER NOTIFIED _____/_____/_____

*NOTE: Reasons identified in boxes 21a or 21b will not preclude a party from raising additional issues at a later date.

23. COMMENTS:

24. ANY EMPLOYER OR INSURER THAT FAILS TO FILE A NOTICE OF CONTROVERSY IN A TIMELY FASHION AS REQUIRED BY THE WORKERS' COMPENSATION ACT AND RULES ADOPTED BY THE BOARD MAY BE OBLIGATED TO PAY BENEFITS/PENALTIES. QUESTIONS PERTAINING TO THIS OBLIGATION MAY BE DIRECTED TO A CLAIMS RESOLUTION SPECIALIST AT ONE OF THE REGIONAL OFFICES LISTED BELOW.

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

AUGUSTA	**BANGOR**	**CARIBOU**	**LEWISTON**	**PORTLAND**
442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE 105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

25. PREPARER NAME (REQUIRED):	26. TELEPHONE NUMBER (REQUIRED):	27. DATE MAILED:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	_____/_____/_____

The State of Maine provides equal opportunity in employment and programs. 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: 1-888-801-9087 or TTY Maine Relay 711. WCB-9 (effective 9/1/2020, revised 3/24/2022)

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

STATEMENT OF COMPENSATION PAID

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/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:			

20. REASON FOR REPORT:

☐ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND) ☐ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

PAYMENT SUMMARY

21. LIST CUMULATIVE TOTALS (DO NOT INCLUDE ANY PENALTY AMOUNTS):

MEDICAL TREATMENT	$	DEATH BENEFIT/FUNERAL EXPENSE (NOT TO EXCEED $7,000.00)	$
WEEKLY COMPENSATION	$	LEGAL EXPENSE (EMPLOYEE RELATED)	$
PERMANENT IMPAIRMENT (PRE 1993 ONLY)	$	LEGAL EXPENSE (EMPLOYER RELATED)	$
EMPLOYMENT REHABILITATION	$	INTEREST AND OTHER PAYMENTS	$
LUMP SUM SETTLEMENT	$		
		TOTAL AMOUNT PAID (DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES)	**$**

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

AUGUSTA	BANGOR	CARIBOU	LEWISTON	PORTLAND
442 CIVIC CTR DR, STE 225 156 STATE HOUSE STATION AUGUSTA, ME 04333-0156 (207) 287-2308 1-800-400-6854	396 GRIFFIN RD, STE105 BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 498-6428 1-800-400-6855	36 MOLLISON WAY LEWISTON, ME 04240-7777 (207) 753-7700 1-800-400-6857	1037 FOREST AVE, STE 11 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858

22. TYPE OR PRINT PREPARER NAME (REQUIRED):	23. TELEPHONE NUMBER (REQUIRED):	24. DATE MAILED:
E-MAIL ADDRESS (REQUIRED):	TOLL-FREE NUMBER:	____/____/____ MM DD YYYY

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WCB-11 (effective 9/1/2020, revised 3/24/2022)

FOR DATES OF INJURY ON AND AFTER JANUARY 1, 2020

WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

AUGUSTA
442 Civic Center Drive, Suite 225
156 State House Station
Augusta, ME 04333-0156
207-287-2308
1-800-400-6854

LEWISTON
36 Mollison Way
Lewiston, ME 04240-5811
207-753-7700
1-800-400-6857

BANGOR
396 Griffin Road, Suite 105
Bangor, ME 04401
207-941-4550
1-800-400-6856

PORTLAND
56 Northport Drive, Suite 201
Portland, ME 04103
207-822-0840
1-800-400-6858

CARIBOU
43 Hatch Drive, Suite 110
Caribou, ME 04736-2347
207-498-6428
1-800-400-6855

Visit our website at:
www.maine.gov/wcb
Statewide TTY: 711

Notice to Employees:

State law requires your employer to provide workers'compensation insurance for its employees. Workers'compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 60 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

It is against the law for employers to misclassify employees as independent contractors for the purposes of avoiding workers' compensation insurance, unemployment coverage, or other employer paid taxes and withholdings. For more information on laws pertaining to the hiring of independent contractors, visit the Worker Misclassification Task Force website at www.maine.gov/labor/misclass.

If you have any questions about your rights, please contact one of the regional offices.

A l'intention des Employes:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVENEZ VOTRE EMPLOYEUR IMMEDIATEMENT. Passé un délai de 60 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers'Compensation Board met des conseillers juridiques à leur disposition.

La loi interdit aux employeurs de classifier fallacieusement leurs salariés comme étant des contractants privés aux fins d`échapper a l`assurance compensatrice-employé, aux indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative a l`utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés) : www.maine.gov/labor/misclass.

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFÍQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 60 días. Así mismo esta reclamación debe hacer referencia a unaccidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

El hecho de no clasificar a los empleados como contratistas independientes, con el propósito de evitar el seguro por compensación al trabajador, cobertura para desempleados, ú otros impuestos pagados y retenidos por el empleador; está en contra de la ley del empleador. Para mayor información acerca de las leyes pertenecientes a la contratación de contratistas independientes, visite el Worker Misclassification Task Force en la página web de www.maine.gov/labor/misclass.

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

ENGLISH
Interpreters Available
When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

SPANISH
Tenemos intérpretes a su disposición
Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

PORTUGUESE
Temos intérpretes à sua disposição
Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

ITALIAN
Abbiamo intèrpreti disponibili
Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un intèrprete sará messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

FRENCH
Des interprètes sont à votre disposition
Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne.

POLISH
Tłumacze dostępni na życzenie.
Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linii.

RUSSIAN
"К вашим услугам имеются переводчики"
"Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите "РАШН"), и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии."

CHINESE
提供口譯服務
打電話請求幫助時，請用英語說"挾音呢斯"(CHINESE)— 我們將爲您提供口譯人員。請不要挂斷電話。

JAPANESE
通訳サービスをご利用いただけます
通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳がでるまでそのままでお待ちください。

KOREAN
한국어 통역을 이용하실 수 있습니다.
도움이 필요하여 전화를 거실 때 영어로 코리언(KOREAN)이라고 말씀하시면 통 역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.

VIETNAMESE
"Có Thông Dịch Viên"
"Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói "VIETNAMESE" để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.

ARABIC
مترجمون شفهيون متيسّرون لخدمتكم
عند إتّصالكم للمساعدة أو لطلب خدمة معيّنة نرجو منكم أن تذكروا (أ-رَ-بِ-ك)ونحن سنقدّم لكم مترجما شفهيا . ابقوا على الخط من فضلكم.

PERSIAN
افراد مترجم در دسترس مي باشند.
را كه بدان صحبت مي كنيد به انگليسي ذكر كنيد تا راجع به امري به ما تلفن مي كنيد، لطفاً نام زباني هنگاميكه براي درخواست كمک يا قطع نكنيد. شما تماس گرفته شود. لطفاً روي خط منتظر بمانيد.
با يک مترجم براي

SOMALI
Turjunaanno waa la helayaa
Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Taleefoonkana ha dhigin.

To the employer: This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. 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 poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY: 711.

WCB-90 (1/1/2020, revised 12/4/2023)

OPTUM®

AmTrust North America
An AmTrust Financial Company

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies, including Walgreens, our preferred provider, and all major chains, are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

AmTrust North America
An AmTrust Financial Company

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
CARRIER/TPA

EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist
SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1614-109-FFWG

Optum
PO Box 152539
Tampa, FL 33684-2539

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias, incluyendo Walgreens, nuestro proveedor preferido, y todas las grandes cadenas de farmacias, forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

AmTrust North America
PORTADORA — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Please provide directly to Pharmacist
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	FF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1614-109-FFWG

RETURN-TO-WORK; A **GREAT** IDEA

We at the AmTrust Group, are convinced that an employer who provides light, or restricted work for injured employees, enjoys numerous benefits. This is not just an opinion, it's something we see day in and day out. Consider:

- Unless an injured worker returns to the workplace within 60 days, chances of him/her ever returning drop dramatically. (resulting in a very expensive permanent disability situation.)
- After 6 months away from the workplace, only 50% chance of return.
- After 12 months, only a 10% chance of return.

Some Return-to Work Benefits Include:

- "Test" of malingering potential. Injured employees who refuse light duty are more prone to being malingerers.
- Opportunity for employer to demonstrate true concern for workers' well-being.
- Promotion of rehabilitation and recovery.
- Lower medical and rehabilitation costs.
- Productivity.
- Morale improvement for the injured worker.
- Ability for the employer to monitor the injured employee's recovery progress.
- Decrease of WC claims costs, with resultant downstream WC premium savings.

(Notice we're not just talking about 'feel-good' issues, but also hard dollars !)

Some common misconceptions (and truths) about Return-to-Work / Light Duty:

Misconception: *We've already got too many "programs" around here, and don't need any more paper*.

Truth: While it is true a written, planned program works best, in many cases a Light Duty "program" can be nothing more than a management understanding of the benefits and principles of Return-to-Work, how it works, and the commitment to 'just do it', when light-duty recommendations are made by WC physicians.

Misconception: *It will get me into an Americans With Disabilities (ADA) "situation".*

Truth: Light-duty and ADA "reasonable accommodation" are two entirely separate issues. Generally, light duty is a temporary assignment, for a relatively short period. ADA accommodations are made for serious, permanent disabilities that impair major life activities.

Misconception*: I'll have to devise a whole new job each time an employee needs light duty.*

Truth: The vast majority of light-duty restrictions require accommodating only one or two factors, such as "no lifting over 10 pounds", or the like. In many cases, if you break the jobs down into individual **tasks**, you'll see that only one or two tasks within the employee's normal job are affected, and can be handled in some other way.

Misconception: *Once an employee gets into a "cushy" light-duty job, s/he'll never leave it, and I'll be stuck with it.*

Truth: Light duty is always defined by, and monitored by the attending physician. An employee on light duty is periodically monitored by the physician for improvement, and is released for full-duty as soon as medically indicated.

Misconception: *We're a union company. Our union won't allow us to pay lower rates, or move employees between classifications, or between bargaining groups.*

Truth: Any Local that objects to a Return-to-Work program should be referred to its national body for guidance. Return to Work is universally recognized as a very positive influence on an injured worker (as well as benefiting the employer). Labor unions, whose major purpose for existence is the benefit of the workers they represent, should not only "tolerate" Return-to-Work programs, but enthusiastically promote, and assist in such programs' implementation and operation. It is strongly suggested that management approach labor representatives to solicit their input, and assistance in making Return to Work a positive force in your workplace.

Misconception: *I might be willing to place a worker in a light-duty position, but I can't afford pay them their full pay, for the decreased productivity.*

Truth: Talk to your WC insuror's claims professional. In many cases, states' WC plans provide for "make-up" pay to replace some, or all of the injured employees' decreased earnings. The goal of getting them back to the workplace, and doing some productive work is that important!

WAGE STATEMENT

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS): XXX -XX-		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? YES ☐ NO ☐
IF YES, GIVE NAME(S):_____
NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.

19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? YES ☐ NO ☐
NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))

20. LIST GROSS EARNINGS FOR EACH WEEK:

WK 1	WEEK ENDING	GROSS EARNINGS	WK 19	WEEK ENDING	GROSS EARNINGS	WK 37	WEEK ENDING	GROSS EARNINGS
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			**WK OF INJURY**		
17			35			**21. TOTAL EARNINGS $**		
18			36			**22. GROSS AVERAGE WEEKLY WAGE $**		

23. COMMENTS:

24. PREPARER NAME (TYPE OR PRINT):	25. TELEPHONE NUMBER: ( )	26. DATE MAILED:
E-MAIL ADDRESS:	TOLL-FREE NUMBER: ( )	_____/_____/_____ MM DD YYYY

The State of Maine provides equal opportunity in employment and programs. 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: 1-888-801-9087 or TTY Maine Relay 711.
WCB-2 (eff. 1/1/13)