| **STATE OF MAINE**  **WORKERS' COMPENSATION BOARD**  **27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027** | | |
| --- | --- | --- |
| 1. REVISION DATE:   \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  MM DD YYYY | | **STATEMENT OF COMPENSATION PAID** | 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. TYPE: INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND) FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED) | | | | | | | | | | | | | |
| **21. LIST CUMULATIVE TOTALS:** | | | | | | | | | | | | | |
| **MEDICAL TREATMENT** (Treatment does not include expenses related to managed care services such as utilization review, case management, and bill review, or to exams performed pursuant to §§ 207 and 312.) | | | $ | | | **DEATH BENEFIT/FUNERAL EXPENSE**  (not to exceed $7,000) | | | | | | $ | |
| **WEEKLY COMPENSATION** (When filing this form as a Final, this amount must match the sum of the Amount Paid on all payment forms) | | | $ | | | **EMPLOYEE RELATED LEGAL EXPENSE** | | | | | | $ | |
| **EMPLOYER RELATED LEGAL EXPENSE** | | | | | | $ | |
| **PERMANENT IMPAIRMENT**  (pre 1993 only) | | | $ | | | **INTEREST AND OTHER PAYMENTS** (Other payments include but are not limited to: expert witness fees, court reporter fees, private investigator fees, medical and other travel costs, costs related to managed care services such as utilization review, case management, and bill review, and exams performed pursuant to §§ 207 and 312) | | | | | | $ | |
| **EMPLOYMENT REHABILITATION** | | | $ | | |
| **LUMP SUM SETTLEMENT** (this amount must match the approved amount on form wcb-10) | | | $ | | |
| **TOTAL AMOUNT PAID** (Do not include any penalty amounts, amounts paid to the “lead” carrier on apportionment cases, or amounts paid by the employer. Do not reduce these totals by the amount of any recoveries, including deductibles.) | | | | | | | | | | | | $ | |
| **COMMENTS:** | | | | | | | | | | | | | |
| **ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS’ COMPENSATION BOARD’S REGIONAL OFFICES:** | | | | | | | | | | | | | |
| **AUGUSTA**  442 CIVIC CTR. DRIVE, STE 225  156 STATE HOUSE STATION  AUGUSTA, ME 04333-0156  (207) 287-2308  1-800-400-6854 | | **BANGOR**  396 GRIFFIN RD, STE 105  BANGOR, ME  04401-5638  (207) 941-4550  1-800-400-6856 | | **CARIBOU**  ONE VAUGHN PL  43 HATCH DR, STE 110  CARIBOU, ME 04736  (207) 498-6428  1-800-400-6855 | | | | **LEWISTON**  36 MOLLISON WAY  LEWISTON, ME  04240-7777  (207) 753-7700  1-800-400-6857 | | | **PORTLAND**  56 NORTHPORT DR, STE 201  PORTLAND, ME  04103  (207) 822-0840  1-800-400-6858 | | |
| 22. PREPARER’S FULL NAME (REQUIRED):  E-MAIL ADDRESS (REQUIRED): | | | 23. TELEPHONE NUMBER (REQUIRED):  ( )  TOLL-FREE NUMBER:  ( ) | | | | | | | 24. DATE SENT TO WCB:  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  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-11B Effective 04/01/2025