

# PETITION FOR AWARD OF COMPENSATION - OCCUPATIONAL DISEASE LAW

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

## EMPLOYEE

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
SOCIAL SECURITY NUMBER: XXX-XX-\_\_\_\_\_  
(only last four digits required)  
BOARD FILE NUMBER: \_\_\_\_\_

## EMPLOYER

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_

## INSURER

NAME: \_\_\_\_\_  
STREET/P.O. BOX: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_

## NOTICE

A party is not required to file a written response to this petition under 39-A M.R.S.A. §307(3). Upon notice of a claim for incapacity or death benefits, however, the employer/insurer must comply with the provisions of 90 MAR 351 Ch.1. §1 or the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S.A. §205(2) and in compliance with 39-A M.R.S.A. §204.

1. Date of incapacity: \_\_\_\_\_  
MONTH DAY YEAR
2. Date employee gave notice of incapacity: \_\_\_\_\_  
MONTH DAY YEAR
3. Date of last exposure: \_\_\_\_\_  
MONTH DAY YEAR
4. Date employment ceased: \_\_\_\_\_  
MONTH DAY YEAR
5. The exposure occurred \_\_\_\_\_  
DESCRIBE HOW THE EXPOSURE HAPPENED  
and the employee developed \_\_\_\_\_  
DESCRIBE THE NATURE OF THE OCCUPATIONAL DISEASE

THEREFORE, the employee asks the board to order benefits pursuant to Title 39 or 39-A, Part 2 (Occupational Disease Law).

\_\_\_\_\_  
SIGNATURE OF PETITIONER

DATED: \_\_\_\_\_  
MONTH DAY YEAR

## FILING INSTRUCTIONS

1. Mail original petition to the Workers' Compensation Board at the above address by regular mail.
2. Mail one (1) copy **by certified mail, return receipt requested** to each other party named in the petition.
3. Keep one (1) copy for yourself and keep the green certified mail cards when returned to you by the U.S. Post Office.

\_\_\_\_\_  
NAME OF EMPLOYEE'S ATTORNEY OR ADVOCATE (IF ANY)

\_\_\_\_\_  
STREET/P.O. BOX

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
TELEPHONE 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: (888) 801-9087 or TTY Maine Relay 711.  
WCB-160 (eff. 1/1/13)