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| 1. REVISION DATE:  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  MM DD YYYY | **DISCONTINUANCE OF COMPENSATION** | | | | 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. 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 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: | | | | |

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| **NOTICE TO EMPLOYEE**  20. YOUR BENEFITS ARE BEING DISCONTINUED FOR THE REASON MARKED BELOW. IF YOU DISAGREE OR HAVE QUESTIONS, PLEASE CONACT THE BOARD AT ONE OF THE REGIONAL OFFICES LISTED BELOW.   |  |  | | --- | --- | | 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)(2)) | OTHER (EXPLAIN):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| 21. PERIOD OF INCAPACITY:  FROM (DATE): THROUGH (DATE):  \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  MM     DD    YYYY  MM     DD    YYYY | | | | | 22. NET WEEKLY CHECK AMOUNT FROM MEMORANDUM OF PAYMENT OR MOST RECENT MODIFICATION:  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 23. TOTAL WEEKLY COMPENSATION PAID FOR THE PERIOD OF INCAPACITY IN BOX 21:  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | 24. DATE THE FINAL PAYMENT WAS MAILED:  \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_     MM     DD    YYYY | | |
| 25. COMMENTS: | | | | | | | |
| **ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS’ COMPENSATION BOARD’S REGIONAL OFFICES:** | | | | | | | |
| **AUGUSTA**  442 CIVIC CTR DR, 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 |
| 26. PREPARER’S FULL NAME (REQUIRED):  E-MAIL ADDRESS (REQUIRED): | | 27. TELEPHONE NUMBER (REQUIRED):  ( )  TOLL-FREE NUMBER:  ( ) | | | | 28. 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-4D (effective 04/01/2025)