

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

1. REVISION DATE:  MM / DD / YYYY	<b>MODIFICATION OF COMPENSATION</b>	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. 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:	

NOTICE TO EMPLOYEE			
20. YOUR EMPLOYER/INSURER IS REQUIRED TO FILE THIS FORM UPON THE MODIFICATION OF YOUR WEEKLY COMPENSATION PAYMENTS. YOUR WEEKLY COMPENSATION PAYMENTS HAVE BEEN MODIFIED FOR THE FOLLOWING REASON(S):			
<input type="checkbox"/> AGREEMENT OF THE PARTIES/BOARD DECISION (RULES CH.8, §12) \$ _____	<input type="checkbox"/> INCREASED EARNINGS WITH SAME EMPLOYER (§205(9)(A)) \$ _____		
<input type="checkbox"/> ADJUSTED WAGE/RATE (RULES CH.1, §5(2)(C)) \$ _____	<input type="checkbox"/> MAX RATE INCREASE (§211) \$ _____		
<input type="checkbox"/> APPORTIONMENT (§354) \$ _____	<input type="checkbox"/> PAID TIME OFF (§221(3)(A)(2)) \$ _____		
<input type="checkbox"/> CHANGE IN PAYMENT TYPE \$ _____	<input type="checkbox"/> RTW WITH SAME EMPLOYER, MODIFIED DUTY (§205(9)(A)) \$ _____		
<input type="checkbox"/> COST OF LIVING ADJUSTMENT \$ _____	<input type="checkbox"/> SOCIAL SECURITY RETIREMENT (§221(3)(A)(1)) \$ _____		
<input type="checkbox"/> DECREASED EARNINGS WITH SAME EMPLOYER (§205(9)(A)) \$ _____	<input type="checkbox"/> THIRD PARTY LIABILITY (§107) \$ _____		
<input type="checkbox"/> DISABILITY INSURANCE (§221(3)(A)(2)-(3)) \$ _____	<input type="checkbox"/> UNEMPLOYMENT COMPENSATION (§220) \$ _____		
<input type="checkbox"/> EMPLOYER FUNDED PENSION (§221(3)(A)(5)) \$ _____	<input type="checkbox"/> WAGE CONTINUATION PLAN (§221(3)(A)(2)) \$ _____		
<input type="checkbox"/> FRINGE BENEFITS (§102(4)(H)) \$ _____	<input type="checkbox"/> OTHER (EXPLAIN): _____ \$ _____		

21. PAYMENT TYPE: <input type="checkbox"/> WEEKLY COMPENSATION <input type="checkbox"/> SPECIFIC LOSS _____ WEEKS <input type="checkbox"/> SALARY CONTINUATION <input type="checkbox"/> OTHER (EXPLAIN): _____	22. BENEFIT TYPE: <input type="checkbox"/> TOTAL (§212) <input type="checkbox"/> PARTIAL (§213) <input type="checkbox"/> FATAL (§215/§355(14)(F))
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23. OLD WEEKLY CHECK AMOUNT: <input type="checkbox"/> FIXED \$ _____ <input type="checkbox"/> VARYING	24. NEW WEEKLY CHECK AMOUNT: <input type="checkbox"/> FIXED \$ _____ <input type="checkbox"/> VARYING	25. EFFECTIVE DATE OF MODIFICATION:  MM / DD / YYYY
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26. COMMENTS:
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**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	PORTLAND 56 NORTHPORT DR, STE 201 PORTLAND, ME 04103 (207) 822-0840 1-800-400-6858
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27. PREPARER'S FULL NAME (REQUIRED):  E-MAIL ADDRESS (REQUIRED):	28. TELEPHONE NUMBER (REQUIRED):  TOLL-FREE NUMBER:	29. DATE SENT TO WCB:  MM / DD / YYYY
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