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

# CERTIFICATE AUTHORIZING RELEASE OF BENEFIT 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, _____, DATE OF BIRTH _____ AUTHORIZE THE EMPLOYER/INSURER TO OBTAIN WRITTEN INFORMATION INDICATING THE NATURE AND AMOUNT OF BENEFITS I RECEIVED OR AM RECEIVING FROM THE FOLLOWING:

☐ SOCIAL SECURITY ADMINISTRATION

☐ EMPLOYEE BENEFITS PLAN

_____
NAME OF EMPLOYEE BENEFIT PLAN

_____
ADDRESS- NUMBER AND STREET

_____
CITY, STATE, ZIP

I UNDERSTAND THAT THE EMPLOYER/INSURER IS ENTITLED TO RECEIVE THIS SOCIAL SECURITY OLD AGE INSURANCE OR EMPLOYEE BENEFIT PLAN INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5) AND THAT **MY FAILURE TO COMPLETE AND RETURN THIS REPORT MAY AFFECT MY WORKERS' COMPENSATION INDEMNITY BENEFITS.** THIS CERTIFICATE OF RELEASE IS VALID FOR ONE YEAR FROM THE DATE OF MY SIGNATURE.

SIGNATURE: _____ DATE: _____

## PART III (COMPLETED BY SOCIAL SECURITY ADMINISTRATION OR EMPLOYEE BENEFIT PLAN ADMINISTRATOR)

THE EMPLOYEE AUTHORIZES THE RELEASE OF BENEFIT INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5). PLEASE PROVIDE THE FOLLOWING INFORMATION TO THE EMPLOYER/INSUER:

1. EFFECTIVE DATE OF ELIGIBILITY: _____
2. CURRENT GROSS MONTHLY AMOUNT: _____
3. PERCENTAGE OF EMPLOYEE BENEFIT PLAN PAID BY EMPLOYER (IF APPLICABLE): _____
4. IF BENEFITS FROM THIS EMPLOYEE BENEFIT PLAN ARE SUBJECT TO REDUCTION BASED ON RECEIPT OF WORKERS' COMPENSATION BENEFITS, PLEASE EXPLAIN:
5. COMMENTS:
6. BENEFIT INFORMATION SENT TO THE EMPOYER/INSURER ON: _____ DATE: _____

SIGNATURE: _____ DATE: _____

PREPARER NAME (TYPE OR PRINT): _____ TELEPHONE NUMBER: _____