WAGE STATEMENT

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

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:	10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION OF INJURY:		

18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FROM EACH ADDITIONAL EMPLOYER.	YES ☐ NO ☐	19. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS; COMPENSATION?.	YES ☐ NO ☐

20.

WK	WEEK ENDING	GROSS EARNINGS	WK			WK		
1			19			37		
2			20			38		
3			21			39		
4			22			40		
5			23			41		
6			24			42		
7			25			43		
8			26			44		
9			27			45		
10			28			46		
11			29			47		
12			30			48		
13			31			49		
14			32			50		
15			33			51		
16			34			52		
17			35			**21. TOTAL EARNINGS**	**$**	
18			36			**22. GROSS AVERAGE WEEKLY WAGE**	**$**	

23. PREPARER NAME AND TITLE (TYPE OR PRINT):	24. TELEPHONE NUMBER:	25. DATE MAILED:

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525

WCB 2 (6/11)

Distribution: (1) Workers' Compensation Board, (2) Employee, (3) Insurer, (4) Employer