Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Report Online

To use the app, you will first need to register on the Great American Insured Portal

https://insuredportal.gaig.com

1. **Click the Request Access link**
2. **Complete the Policyholder Registration form**
3. **Confirm the Insured Portal system generated "Identity Verification" email**

Preregistration Required

Call our reporting center

877-836-1555

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

GREAT AMERICAN INSURANCE GROUP

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

STATE OF MAINE
WORKERS' COMPENSATION BOARD
DEERING BUILDING AMHI COMPLEX
27 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0027

ANGUS S. KING, JR.
GOVERNOR

PAUL R. DIONNE
EXECUTIVE DIRECTOR

NOTICE

December 31, 1998

Re: Instructions for Completing the Employer's First Report of Occupational Injury or Disease, WCB-1 (10/98)

Dear Interested Party:

On October 20, 1998, the Board of Directors approved the revised First Report of Injury in order to collect claims performance data for the generation of Audit and Quarterly Compliance Reports

Effective January 1, 1999, the use of this form becomes mandatory.

This Notice provides instructions on the completion of the revised First Report of Injury.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE WCB-1 (10/98)

- A mandatory box means that the First Report will be returned to the employer and the insurer/TPA for completion. A claim will not be started in the Workers' Compensation Board (WCB) system.

- A required box means that a claim will be started in the Workers' Compensation Board system and a letter will be sent to the employer and the insurer/third-party administrator (TPA) indicating further information is required. The employer will have 14 days to correct the First Report previously sent with the information in the required boxes completed.

- All other boxes should be completed if the information is known.

REASON FOR REPORT SECTION

- It is mandatory that at least one box from 2(a) through 7(a) be check-marked.

2(a). If 2(a) is completed, then 2(b) is required.
5. If 5 is check-marked, then Date of Death is required.
6(a). If 6(a) is check-marked, then 6(b) and 6(c) should be completed.
7(a). If 7(a) is check-marked, then 7(b) and 7(c) should be completed.

EMPLOYER SECTION

8. Required.
9. Required.
10. Mandatory.
11. Required.
12. Required.
13. Required.
14. Required.
18. Required.

PHONE: (207) 287-3751 TDD: (207) 287-6119 FAX: (207) 287-7198

INSURER, TPA, AND SELF-ADMINISTERED SECTION

It is required that one box be check-marked.

☐ Insurer ☐ TPA ☐ Self-administered

If the Insurer or TPA box is check-marked, then boxes 19, 22, 23, 24, and 25 are required.

If the Self-Administered Employer box is check-marked, then boxes 19 through 26 should be left blank.

EMPLOYEE SECTION

27. **Mandatory.**
28. **Mandatory.**
31. Required.
33. Required.
34. Required.
35. Required.
36. Required.
37. Required.
41. Required.

CLAIM INFORMATION SECTION

42. **Mandatory.**
43. **Mandatory** if boxes 2(a) and 2(b) are check-marked.
44. Required.
45. Required if the Insurer or TPA box is check-marked. Not required if Self-administered Employer box is check-marked.
46. Required.
47. Required if 2(a) is check-marked and, if Yes, then the date is required.
48. Required.
49. Required.
52. Required.

PREPARER INFORMATION SECTION

57. Required.

Please contact me if you have any questions.

Sincerely,

Steve Minkowsky
Deputy Director of Benefits Administration

SM/amp

cc: Paul R. Dionne
Executive Director

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ___/___/___ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ___/___/___ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ___/___/___ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ___/___/___ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ___/___/___ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER: XXX-XX-	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ___/___/___ MM DD YYYY
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ___/___/___ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ___/___/___ MM DD YYYY DATE EMPLOYER NOTIFIED: ___/___/___ MM DD YYYY	43. DATE OF INCAPACITY: ___/___/___ MM DD YYYY DATE EMPLOYER NOTIFIED: ___/___/___ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ___/___/___ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ___/___/___ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:	55. HEALTH CARE PROVICER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ___/___/___ MM DD YYYY

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 Maine Relay 711.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):
1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ___/___/___ (MM DD YYYY)

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ___/___/___ (MM DD YYYY) 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ___/___/___ (MM DD YYYY)

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ___/___/___ (MM DD YYYY) 7c. DATE CORRECTION SENT TO WCB: ___/___/___ (MM DD YYYY)

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER: XXX-XX-	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ___/___/___ (MM DD YYYY)
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ___/___/___ (MM DD YYYY)	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐ YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ___/___/___ (MM DD YYYY) DATE EMPLOYER NOTIFIED: ___/___/___ (MM DD YYYY)	43. DATE OF INCAPACITY: ___/___/___ (MM DD YYYY) DATE EMPLOYER NOTIFIED: ___/___/___ (MM DD YYYY)	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ___/___/___ (MM DD YYYY) 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ___/___/___ (MM DD YYYY)

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO	55. HEALTH CARE PROVICER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ___/___/___ (MM DD YYYY)

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 Maine Relay 711.

WCB-1 (eff. 1/1/13)

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ___/___/___ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ___/___/___ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ___/___/___ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ___/___/___ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ___/___/___ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER: XXX-XX-	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ___/___/___ MM DD YYYY
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ___/___/___ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ___/___/___ MM DD YYYY DATE EMPLOYER NOTIFIED: ___/___/___ MM DD YYYY	43. DATE OF INCAPACITY: ___/___/___ MM DD YYYY DATE EMPLOYER NOTIFIED: ___/___/___ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ___/___/___ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ___/___/___ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:	55. HEALTH CARE PROVICER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ___/___/___ MM DD YYYY

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 Maine Relay 711.

WCB-1 (eff. 1/1/13)

WORKERS' COMPENSATION

WORKERS' COMPENSATION BOARD REGIONAL OFFICES

AUGUSTA
24 Stone Street, Suite 102
Augusta, ME 04330
207-287-2308
1-800-400-6854

LEWISTON
36 Mollison Way
Lewiston, ME 04240-5811
207-753-7700
1-800-400-6857

BANGOR
106 Hogan Road, Suite 1
Bangor, ME 04401
207-941-4550
1-800-400-6856

PORTLAND
62 Elm Street
Portland, ME 04101
207-822-0840
1-800-400-6858

CARIBOU
43 Hatch Drive, Suite 110
Caribou, ME 04736-2347
207-498-6428
1-800-400-6855

Visit our website at:
www.maine.gov/wcb
Statewide TTY: 1-877-832-5525

Notice to Employees:

State law requires your employer to provide workers'compensation insurance for its employees. Workers'compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 90 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers' Compensation Board to help injured workers.

It is against the law for employers to misclassify employees as independent contractors for the purposes of avoiding workers' compensation insurance, unemployment coverage, or other employer paid taxes and withholdings. For more information on laws pertaining to the hiring of independent contractors, visit the Worker Misclassification Task Force website at www.maine.gov/labor/misclass.

If you have any questions about your rights, please contact one of the regional offices.

A l'intention desEmployes:

D'après les lois de l'Etat du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d'un accident du travail.

Si vous êtes victime d'un accident du travail, PREVENEZ VOTRE EMPLOYEUR IMMEDIATEMENT. Passé un délai de 90 jours, vous risquez de perdre vos droits à l'indemnisation. Au-delà de deux ans, votre déclaration n'est plus recevable. Pour aider les victimes d'un accident du travail, le Workers'Compensation Board met des conseillers juridiques à leur disposition.

La loi interdit aux employeurs de classifier fallacieusement leurs salariés comme étant des contractants privés aux fins d'échapper a l'assurance compensatrice-employé, aux indemnités de chômage, ou aux autres charges et retenues dues par employeur. Pour plus de détails sur la législation relative a l'utilisation des services privés, visitez le site internet de Worker Misclassification Task Force (Unité anti-fraude en matière de classification des salariés) : www.maine.gov/labor/misclass.

Si vous n'êtes pas sûr de vos droits, veuillez contacter l'un des bureaux régionaux.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFÍQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 90 días. Así mismo esta reclamación debe hacer referencia a unaccidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers' Compensation Board).

El hecho de no clasificar a los empleados como contratistas independientes, con el propósito de evitar el seguro por compensación al trabajador, cobertura para desempleados, ú otros impuestos pagados y retenidos por el empleador; está en contra de la ley del empleador. Para mayor información acerca de las leyes pertenecientes a la contratación de contratistas independientes, visite el Worker Misclassification Task Force en la página web de www.maine.gov/labor/misclass.

En caso de tener cualquier pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.

ENGLISH

Interpreters Available

When calling for assistance, please say the name of your language in English and an interpreter will be called for you. Please stay on the line.

SPANISH

Tenemos intérpretes a su disposición

Si necesita que le atiendan en español por favor diga "Spanish" y le conectaremos con un intérprete. Por favor manténgase en la línea.

PORTUGUESE

Temos intérpretes à sua disposição

Se precisar de atendimento em Português, por favor diga "Portuguese" e um intérprete será prontamente chamado. Por favor, aguarde na linha.

ITALIAN

Abbiamo interpreti disponibili

Se avete bisogno di assistenza in Italiano, Vi preghiamo di dire "Italian" e un interprete sarà messo a Vostra disposizione. Vi preghiamo di rimanere in linea.

FRENCH

Des interprètes sont à votre disposition

Lorsque vous appelez pour demander de l'aide, prononcez le mot "French" et nous mettrons un interprète à votre disposition. Prière de rester en ligne.

POLISH

Tłumacze dostępni na życzenie.

Aby uzyskać pomoc tłumacze, proszę powiedzieć po angielsku "Polish" i czekać na linii.

RUSSIAN

"К вашим услугам имеются переводчики"

"Когда Вы обращаетесь за помощью по телефону, пожалуйста скажите, что Вы говорите по-русски (произнесите "РАШН"); и мы обеспечим Вас переводчиком. После этого, пожалуйста, оставайтесь на линии."

CHINESE

提供口譯服務

打電話請求幫助時，請用英語說 "拱音呢斯" (CHINESE)— 我們將為您提供口譯人員。請不要挂斷電話。

JAPANESE

通訳サービスをご利用いただけます

通訳を必要とされる場合は「ジャパニーズ」とおっしゃり、通訳がでるまでそのままでお待ちください。

KOREAN

한국어 통역을 이용하실 수 있습니다.

도움이 필요하여 전화를 거실 때 영어로 코리언 (KOREAN)이라고 말씀하시면 통 역자를 연결해 드릴 것입니다. 전화를 끊지 마시고 기다리십시오.

VIETNAMESE

"Có Thông Dịch Viên"

"Khi gọi điện thoại để được giúp đỡ, xin quý vị hãy nói "VIETNAMESE" để chúng tôi cho thông dịch viên giúp quý vị. Xin quý vị chờ trên đường dây.

ARABIC

مترجمون شفهيون متيسرون لخدمتكم

عند إتصالكم للمساعدة أو لطلب خدمة معينة نرجو منكم أن تذكروا (أ-ز-ب-ك) ونحن سنقدم لكم مترجما شفهيا . ابقوا على الخط من فضلكم.

PERSIAN

افراد مترجم در دسترس مي باشند.

را كه بدان صحبت مي كنيد به انگليسي ذكر كنيد تا راجع به امري به ما تلفن مي كنيد، لطفاً نام زباني قطع نكنيد. هنگاميكه براي درخواست كمک با شما تماس گرفته شود. لطفاً روي خط منتظر بمانيد.

با يک مترجم براي

SOMALI

Turjunaanno waa la helayaa

Marka aad caawinaad inoogu soo yeeraneysid, fadhlan luqaddaada af Ingiriisi inoogu sheeg turjubaan ayaa lguugu yeeri doonaaye. Taleefoonkana ha dhigin.

To the employer: This notice must be posted in a conspicuous place upon your premises accessible to employees. 39-A MRSA §406. 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 poster is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: (888) 801-9087 or TTY (877) 832-5525.