SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT

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

EMPLOYER/INSURER COMPLETES BOXES 1 TO 17

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:		

EMPLOYEE COMPLETES BOXES 18 TO 21

18.

FEDERAL TAX FILING STATUS

☐ **SINGLE**

☐ **MARRIED/JOINT**

☐ **SINGLE/HEAD OF HOUSEHOLD**

☐ **MARRIED/SEPARATE**

.19.

DEPENDENT(S)

DEPENDENT NAMES(S) (IF NONE, SO STATE)	RELATHIONSHIP (I.E., SPOUSE, DAUGHTER, SON)	DATE OF BIRTH	SOCIAL SECURITY NUMBER (IF NONE, SO STATE)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

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

THIS DOCUMENT MAY BE PRODUCED IN ALTERNATIVE FORMATS SUCH AS BRAILLE, LARGE PRINT AND AUDIOTAPE.

WCB 2A (8/94)