Claim Department
P.O. Box 3606
Portland, ME 04104

ATTN: JOHN HERRIGEL
MOC RAW BAR LLC
22 FISH HOUSE COVE
PHIPPSBURG, ME 04562

MEMIC

Claim Department

www.memic.com

261 Commercial Street
P.O. Box 3606
Portland, ME 04104
207-791-3300/1-800-660-1306
fax 207-791-3334

Claim Reporting
1-800-MEMICWC

November 27, 2023

MOC RAW BAR LLC
22 FISH HOUSE COVE

PHIPPSBURG, ME 04562

Re: Claim Number: 23115891
Employee: Olivia Richards
Date of Injury: 11/17/2023

Dear Policyholder:

Thank you for providing a First Report of Injury for the above referenced claim. Since this employee may be entitled to wage replacement benefits, the below noted forms need to be completed and returned.

☒ Wage statement completed with this employee's gross wages, or those of a comparable employee, on a weekly basis for the 52 weeks of employment prior to 11/17/2023.

☒ Fringe benefits worksheet completed with any fringe benefits you pay to/on behalf of the employee if you anticipate these benefits will stop during the employee's incapacity. If these benefits do stop the value of them must be included in determining the employee's gross pre-injury average weekly wage.

☒ Workers' compensation task analysis to be completed describing the employee's job as the time of this injury. This will assist the medical provider in determining when the employee has recovered sufficiently to be able to return to this position or to identify which tasks may need to be modified to allow a return to work.

To be certain you are in full compliance with the law immediate attention to the wage statement request is needed. It is required that the appropriate wage statement is filed with the Workers' Compensation Board (WCB) within 30 days of filing the Memorandum of Payment. If the WCB has not received the proper forms, the Board's Payments Division will refer the matter to their Abuse Investigation Unit for a penalty's assessment. Please note, these penalties are NOT covered by your worker's compensation insurance policy.

Should you have any questions please contact me at (207) 791-3422.

Sincerely,

Kristen Bouchard
Claim Handler

Encl

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MAINE EMPLOYERS' MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION TASK ANALYSIS

A t*ask* is defined as one of the distinct activities that constitute logical and necessary steps in the performance of a job. A *task analysis,* for the purpose of this section is the evaluation of the physical requirements of each task of a particular job/work assignment.

Employee Olivia Richards Claim Number 23115891
Employer MOC RAW BAR LLC
Employer Address: 22 FISH HOUSE COVE PHIPPSBURG, ME 04562
Complete the following information to describe the employee's job at the time of injury:
Job Title _____ Usual Job? ☐ YES ☐ NO
General description/purpose: _____
_____
_____
Department _____ Supervisor _____
Description of Tasks (use additional page(s) as needed:
1. _____
2. _____
3. _____
4. _____
5. _____
Tools & Equipment _____
Describe Special Demands _____
_____

PHYSICAL DEMANDS

Complete the following to who the *maximum* physical demand for all the tasks listed above.
Example, if tasks 1-4 require no bending but task 5 requires "Occasional" bending, the overall job must be rated as requiring occasional bending.

JOB REQUIRES: Part of day	Continuous 100-67%	Frequent 66-34%	Occasional 33-1%	**Maximum lifting/carrying of lbs**
Bending				**Frequent lifting carrying of lbs**
Kneeling				
Squatting				**WORK SCHEDULE**
Climbing				Number of hours per day:
Standing				Number of hours per week:
Walking				
Sitting				Does job require repetitive motions? Check if applicable
Reaching				Right ☐ wrist ☐ elbow ☐ shoulder ☐ ankle
Driving				Left ☐ wrist ☐ elbow ☐ shoulder ☐ ankle
Fine motor skills				

ATTACH JOB DESCRIPTION (IF AVAILABLE)

_____ _____ _____
Completed by Title Date

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

WAGE STATEMENT

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):	
Richards	Olivia		XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	**8. CITY:**	**9. STATE:**	**10. ZIP:**	**11. HOME PHONE NUMBER:**
unknown	Portland	ME	04101	( )
12. DATE OF INJURY: 11/17/2023 (MM DD YYYY)	**13. SPECIFIC INJURY OR ILLNESS:** Punctures, except bites		**14. BODY PARTS (S) AFFECTED:** Hand(s), except finger(s)	

EMPLOYER/INSURER

15. INSURER FILE NUMBER:	16. EMPLOYER NAME:	17. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:
23115891	MOC RAW BAR LLC	22 FISH HOUSE COVE, PHIPPSBURG, ME, 04562 2007650538
18. INSURER NAME:	**19.INSURER MAILING ADDRESS AND PHONE NUMBER:**	
Maine Employers' Mutual Insurance Co.	261 Commercial St, P O Box 3606, Portland, ME 04104-3606	800-660-1306

20. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? YES ☐ NO ☑
IF YES, GIVE NAME(S):_____
NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.

21. DOES EMPLOYEE RECEIVE FRINGE BENEFITS THAT MAY STOP WHILE ON WORKERS' COMPENSATION? YES ☐ NO ☐
NOTE: THE EMPLOYER SHALL RECALCULATE THE AVERAGE WEEKLY WAGE IF/WHEN FRINGE BENEFITS CEASE (SEE RULE 1.5(2))

22. LIST GROSS EARNINGS FOR EACH WEEK:

WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS	WK	WEEK ENDING	GROSS EARNINGS
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			**WK OF INJURY**		
17			35			**23. TOTAL EARNINGS**		$
18			36			**24. GROSS AVERAGE WEEKLY WAGE**		$

25. COMMENTS:

26. TYPE OR PRINT PREPARER NAME (REQUIRED): John Herrigel	27. TELEPHONE NUMBER (REQUIRED): 2076505383	28. DATE MAILED:
E-MAIL ADDRESS (REQUIRED): Johnherrigel@gmail.com	TOLL-FREE NUMBER: ( )	____/____/____ (MM DD YYYY)

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.
WCB-2 (eff. 2020)

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

1. REVISION DATE: _____/_____/_____ MM DD YYYY	**FRINGE BENEFITS WORKSHEET**	2. WCB FILE NUMBER (if known):

EMPLOYEE

3. EMPLOYEE LAST NAME:	4. FIRST NAME:	5. MI.:	6. SOCIAL SECURITY NUMBER (last 4 digits):	
Richards	Olivia		XXX-XX-	
7. STREET/P.O. BOX MAILING ADDRESS:	**8. CITY:**	**9. STATE:**	**10. ZIP:**	**11. HOME PHONE NUMBER:**
unknown	Portland	ME	04101	( )
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Maine Employers' Mutual Insurance Co.	261 Commercial St, P O Box 3606, Portland, ME 04104-3606	800-660-1306

PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).

NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.

20. **Fringe Benefit**	**Provided**	**Continues while Employee is out of work**	**Date Benefits End**	**Weekly Cost of Benefits to Employer**
Health Benefits (incl. insurance)	Yes ☐ No ☐	Yes ☐ No ☐		$
Dental Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Disability Insurance (incl. short and long term)	Yes ☐ No ☐	Yes ☐ No ☐		$
401K	Yes ☐ No ☐	Yes ☐ No ☐		$
Life Insurance	Yes ☐ No ☐	Yes ☐ No ☐		$
Education/Training	Yes ☐ No ☐	Yes ☐ No ☐		$
Pension	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$
Other (please list):	Yes ☐ No ☐	Yes ☐ No ☐		$

21. TYPE OR PRINT PREPARER NAME (REQUIRED): John Herrigel E-MAIL ADDRESS (REQUIRED): Johnherrigel@gmail.com	22. TELEPHONE NUMBER (REQUIRED): 2076505383	23. DATE MAILED: _____/_____/_____ MM DD YYYY