

## Request for Review

Employer or  Representative

This form is to ask for a review of a benefits decision you have received in a letter from the WCB. If you have new information which has not been provided to the Adjudicator or Case Manager, please forward that information to their attention. This will ensure that they have considered all relevant information in considering this claim.

You and the worker have a right to see and respond to information related to a review of a claim. You and the worker will be notified by mail of the Review Office's decision and reasons.

For more information, see Policy 21.00 *Review Office* on the WCB website at [www.wcb.mb.ca](http://www.wcb.mb.ca) or call the Review Office at (204) 954-4462 or toll free 1 (800) 362-3340, extension 4462.

Worker Name	Claim Number
<p>I do not agree with the WCB decision in a letter dated _____ that stated:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> The claim was accepted.</li> <li><input type="checkbox"/> A late reporting penalty was applied.</li> <li><input type="checkbox"/> Wage loss benefits were paid beyond _____.[day/month/year]</li> <li><input type="checkbox"/> My request for cost relief was denied in a written decision.</li> <li><input type="checkbox"/> Other (please explain)_____.</li> </ul>	

My reasons for not agreeing with the decision are:

Send a copy of claim file information relevant to the above decision(s).

Please sign and mail or fax to:  <b>Review Office</b> <b>333 Broadway</b> <b>Winnipeg, MB R3C 2X4</b>  <b>Fax: (204) 954-4999</b>  <b>Toll Free Fax: 1 (877) 872-3804</b>	Employer Address		
	City	Province	Postal Code
	Authorized Signature		Date
	Representative Name (please print)		