

This form is to ask for a review of a benefits decision you received in a letter from the WCB. Please attach any new information for the review.

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

For more information, see Policy 20.10 *Reconsiderations* on the WCB website at [www.wcb.mb.ca](http://www.wcb.mb.ca) or call the Review Office at 204-954-4321 or toll free at 1-855-954-4321

Worker Name	Claim Number
<p>I do not agree with the WCB decision in a letter dated (DD/MM/YYYY) _____ that stated:</p> <p><input type="checkbox"/> My claim was not accepted.</p> <p><input type="checkbox"/> My wage loss benefits were not paid after _____ (DD/MM/YYYY).</p> <p><input type="checkbox"/> Payment for my treatment was stopped or not covered.</p> <p><input type="checkbox"/> My wage loss benefits were reduced.</p> <p><input type="checkbox"/> Other (please explain) _____</p>	

My reasons for not agreeing with the decision are:

Worker Address		
City	Province	Postal Code
Signature of Worker	Date (DD/MM/YYYY)	
Worker Representative (please print name)		

Please sign and mail or fax to:

**Review Office**  
333 Broadway  
Winnipeg, MB R3C 2X4

Fax: 204-954-4999  
Toll Free Fax: 1-877-872-3804

For more information:

Call: 204-954-4321  
Outside Winnipeg Call Toll Free:  
1-855-954-4321 Email:  
[ReviewOffice@wcb.mb.ca](mailto:ReviewOffice@wcb.mb.ca)