

If you received a decision you do not agree with and have attempted to resolve the matter with the primary decision maker, you may submit a request for a reconsideration by completing this form. You will be notified that your request has been received, the anticipated date your request will be reviewed and when you can expect a response.

For information about the Reconsideration Process please see Policy 20.10 - Reconsiderations

Contact information

I am the <input type="checkbox"/> Employer <input type="checkbox"/> Employer Representative			
Applicant Name (Print First & Last Name)		Employer Representative Organization Name (If applicable)	
Applicant Address	City	Province	Postal Code
Applicant Email		Applicant Telephone Number	

Decision to be reconsidered

<input type="checkbox"/> Decision about a Worker's Claim	➡	Worker Name	Worker Claim Number
<input type="checkbox"/> Decision about an Employer or Employer Account	➡	Employer Name	Employer Account Number
Decision Date (dd/mm/yyyy)		Decision Made By (If available)	
I am requesting reconsideration of the following decision(s):			

Reason(s) for request

My reason(s) why the decision(s) should be reconsidered is (are): ☐ Please check here if attaching additional pages

Request for information

☐ I am requesting a copy of file information relevant to the above decision(s).*

*Subject to *The Freedom of Information and Protection of Privacy Act* and *The Personal Health Information Act*

Applicant Signature	Date (dd/mm/yyyy)
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Submit your request to: WCB of Manitoba Attention: Review Office

By Email:
ReviewOffice@wcb.mb.ca

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

Mail:
333 Broadway
Winnipeg MB R3C 4W3