WCB Workers Compensation Board of Manitoba

Request for Review

☐ Worker or ☐ Representative

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 or call the Review Office at 204-954-4321 or toll free at 1-855-954-4321

Worker Name	Claim Number

I do not agree with the WCB decision in a letter dated (DD/MM/YYYY) _____ that stated:

- ☐ My claim was not accepted.
- ☐ My wage loss benefits were not paid after_____(DD/MM/YYYY).
- ☐ Payment for my treatment was stopped or not covered.
- ☐ My wage loss benefits were reduced.
- ☐ Other (please explain)_____

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 4W3

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