WCB Workers Compensation Board of Manitoba

333 Broadway – Winnipeg MB R3C 4W3
Telephone (204) 954-4922 – Fax (204) 954-4999
Outside Winnipeg Call Toll Free 1 (800) 362-3340
Toll Free Fax 1 (877) 872-3804
ReviewOffice@wcb.mb.ca

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 21.00 *Review Office* on the WCB website at www.wcb.mb.ca or call the Review Office at (204) 954-4669 or toll free at 1 (800) 362-3340, extension 4669.

Worker Name	Claim Number

I do not agree with the WCB decision in a letter dated _____ that stated:

- ☐ My claim was not accepted.
- ☐ My wage loss benefits were not paid after_____.[day/month/year]
- ☐ 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:

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

Worker Address		
City	Province	Postal Code
Signature of Worker	Date	
Worker Representative (please print name)		