WCB Workers Compensation Board of Manitoba

Employer Request for Reconsideration

333 Broadway, Winnipeg, MB R3C 4W3 | 204-954-4321 | Toll free: 1-855-954-4321 | wcb.mb.ca

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 ☐ Employer ☐ 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

☐ Decision about a Worker's Claim ⇨	Worker Name	Worker Claim Number
☐ 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)

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