REQUEST FOR INTERNAL RECONSIDERATION

P.O. Box 757, 14 Weymouth Street, Charlottetown, PE C1A 7L7 www.wcb.pe.ca
Phone: (902) 368-5680 Toll-free: 1-800-237-5049 Fax: (902) 368-5696

IMPORTANT

To request a reconsideration of a decision of the Workers' Compensation Board, you must complete and return this form **within NINETY (90) DAYS** of the date of notification of the decision.
(where the decision was made after April 1, 2002)

Contact Information

Given Names	Last Name	Employer Name	
Address			
Home Phone	Work Phone	Case ID # (if applicable)	Firm # (if applicable)

Reconsideration Information

I am:	I wish a reconsideration of:
☐ a Worker ☐ an Employer ☐ a Dependent of a Worker	☐ a claim decision ☐ an employer assessment or classification decision ☐ other

Reconsideration Issues (attach extra paper if required)

ISSUE 1	Date of Decision:	Name of Decision Maker:

State the reason why you disagree with the decision?

How do you believe this issue can be resolved?

ISSUE 2	Date of Decision:	Name of Decision Maker:

State the reason why you disagree with the decision?

How do you believe this issue can be resolved?

Representation

☐ I intend to represent myself	☐ I intend to be represented by the Worker Advisor ☐ I intend to be represented by the Employer Advisor ☐ Other Representative

Representative Name	Phone Number

Address

Representative Signature:	Date:

READ BEFORE SIGNING

1. If you have indicated you will have representation, all future correspondence will be addressed to the representative and not the applicant.

2. Both you and your representative must sign this form.

3. Materials and submissions, arguments, or reasons <u>must</u> be submitted in writing with this form.

4. It is recommended you obtain a copy of the file.

Applicant Signature

Applicant Signature:	Date:

The information provided to the Workers Compensation Board of PEI is protected by the provisions of the Freedom of Information and Protection of Privacy Act.