

Disability & Rehabilitation Plan Request for Appeal Hearing

HEB Manitoba Use Only

SECTION 1: MEMBER INFORMATION

Member Name: _____

Member Address: _____

Claim ID: _____ HEB ID: _____

SECTION 2: APPEAL INFORMATION

Please provide a brief summary of the nature of your Appeal.

Select one (As per *Terms of Reference for Appeal Hearing*):

- ☐ Appeal Hearing in writing
- ☐ Appeal Hearing in person (You will be required to attend in person. If you are incapacitated, a representative may attend in your place.)

If a Representative(s) will be accompanying you, or attending in your place, please provide their name and their relationship to you (i.e. union representative, lawyer/legal counsel, spouse, physician).

Name(s) of Representative(s)

Relationship to Member

_____	_____
_____	_____
_____	_____
_____	_____



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SECTION 3: AUTHORIZATION TO RELEASE INFORMATION

I authorize the Healthcare Employees' Benefits Plan to release any and all relevant documents pertaining to my Disability Claim, including medical information, to the Arbitrator, my Representative(s), and any Professional whom the Arbitrator may deem necessary to review.

Member Name: _____

Member Signature: _____ Date Signed: _____
DD MMM YYYY

SECTION 4: FORM RETURN

Please submit form to the Disability & Rehabilitation Department:

Email

DRinfo@hebmanitoba.ca

Fax

204-975-1165

Mail

HEB Manitoba
900-200 Graham Avenue
Winnipeg MB R3C 4L5