CLEAR FORM

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Disability & Rehabilitation Plan

Request for Appeal Hearing

Member Name: _____ Phone Number: _____

Mailing Address: _____ _____ _____ _____
Town/City Province Postal code

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 of Representative(s)	Relationship to Member
_____	_____
_____	_____
_____	_____
_____	_____

Authorization to Release Information

I hereby 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.

Employee Signature: _____ Date: _____ | _____ | _____
DD MMM YYYY

Please return completed form to the Healthcare Employees' Benefits Plan

No further action regarding your Appeal can be taken until this form is completed and returned to:
Healthcare Employees' Benefits Plan
Attn: Sherri Norris-Dyck, Disability & Rehabilitation Manager, Claims Specialists
1000-200 Graham Avenue
Winnipeg MB R3C 4L5