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.)

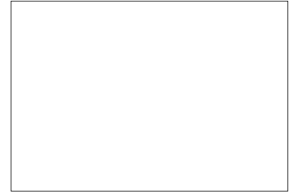
If a Representative(s) will be accompanying you, or attending in your place, please provide their name and their relationship to you (i.e. union representative, lawyer/legal counsel, spouse, physician).

Name(s) of Representative(s)	Relationship to Member
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

HEB Manitoba
HEALTHCARE EMPLOYEE BENEFIT PLANS

Disability & Rehabilitation Plan Request for Appeal Hearing

HEB Manitoba Use Only



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:

Mail
Sherri Norris-Dyck
Assistant Director
Disability & Rehabilitation Department
HEB Manitoba
900-200 Graham Avenue
Winnipeg MB R3C 4L5