

# Union Construction Workers' Compensation Program

Administered by Wilson-McShane Corporation

3001 Metro Drive, Suite 500  
Bloomington, MN 55425-1412

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Phone: (952) 851-3501

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## APPLICATION FOR ARBITRATION

Employee \_\_\_\_\_ Date of Injury/Illness \_\_\_\_\_  
Address \_\_\_\_\_ Social Security No. \_\_\_\_\_  
\_\_\_\_\_ Employer \_\_\_\_\_  
Telephone \_\_\_\_\_ Insurer/TPA \_\_\_\_\_

**Name of Mediator**

**Date of Mediation Session**

**Explain the remaining issues/problems that the mediation session did not resolve:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Intervention Claims: Name, address and telephone number of all parties who have paid benefits related to this claim and health care providers who have not yet been paid for their services:**

**Name**

**Address**

**Telephone**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please make certain that the arbitrator is aware of all intervention claims.**

I request arbitration due to a dispute regarding a claim filed for Workers' Compensation. I hereby authorize the assigned arbitrator to be furnished with any information or facts regarding this injury including rehabilitation reports, psychological, aptitude and interest tests, medical records, medical treatment and prognosis, estimates of disability, and recommendation for further treatment. This information is provided for the evaluation and handling of the purported dispute. Further, I understand that if I decide not to attend a scheduled arbitration and fail to give the arbitrator 48 hours notice prior to the scheduled arbitration, I will be responsible for the payment of a \$200 cancellation fee.

\_\_\_\_\_  
Filing Party (Employee, Insurer or Employer)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**Please submit copies to all parties, their attorneys, and the Union Construction Workers' Compensation Program.**