Application for Arbitration

UCWCP
Union Construction Workers' Compensation Program
Administered by Wilson-McShane Corporation
www.ucwcp.com

Employee Name	Telephone	Email	
Street Address	City	State	Zip
WID #	Date of Injury/Illness		
Employer	Insurer/TPA	Claim #	
Name of Mediator (if applicable)	Date of Mediation Session (if applicable)		

Please outline the issues at dispute:

Parties:
Name, address and telephone number of all parties:

Employer Name	Email	Telephone
Insurer Name	Email	Telephone
Applicant Attorney Name (if applicable)	Email	Telephone
Defense Attorney Name (if applicable)	Email	Telephone
QRC Name (if applicable)	Email	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.

Filing Party (Employee, Insurer, or Employer)	Telephone	Date

Please email the completed form to agascoigne@wilson-mcshane.com and copy all parties to your request.