Request for Facilitation

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 #	

Explain the issues/problems at dispute in detail:

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

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

Please email the completed form to agascoigne@wilson-mcshane.com and copy all parties to your request. Include any additional documents or medical records regarding the dispute when submitting.

The Program will review your request and respond in 48 hours.