MAINE DEPARTMENT OF LABOR	Maine Department of Labor Paid Family Medical Leave Program Appeals Unit **NOTICE OF REQUEST TO APPEAL**	

NOTICE OF REQUEST TO APPEAL FORM

An appeal of a claim for benefits cannot be filed until a reconsideration determination has been made. A copy of the decision letter must be included with your request.

Your contact information

Claim ID or Case Number:

Name (first and last): Phone:

Email address:

Current mailing address: City:

State: Zip:

Additional information

Employer name: Contact Number:

Initial Determination Date: Reconsideration Decision Date:

If you will be represented or assisted by another party, provide their information below:

Name (first and last):

Phone number:

Email address:

Accommodations Needed (interpreter, in person hearing, presence of advocate or support person):

Please tell us why you disagree with the decision you are appealing. Attach additional sheets if needed.

Signature:

Date: