# CC-FORM-211

**WORKERS COMPENSATION COMMISSION**
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 73105

THIS SPACE FOR COMMISSION USE ONLY

Send original and 4 copies to Workers' Compensation Commission
and 1 copy to the Qualified Employer

***Please type or print. Enter dates in MM/DD/YY format.***

| | |
|---|---|
| Full Name of Claimant Aggrieved by Adverse Benefit Determination of the Qualified Employer's Appeals Committee | |
| Employee's Social Security Number (LAST 4 DIGITS ONLY)<br>XXX-XX-_____ | Date of Injury/Death |
| Name of Qualified Employer (Respondent) | Date Claimant Received the Adverse Benefit Determination of the Qualified Employer's Appeals Committee |
| Qualified Employer's Insurance Carrier or Qualified Employer's Designation as Self-Insured | **COMMISSION FILE NO.** |

## REQUEST FOR REVIEW OF ADVERSE BENEFIT DETERMINATION

Pursuant to 85A O.S., §211, the Claimant respectfully requests the Workers' Compensation Commission sitting en banc to review an adverse benefit determination upheld by the above named Qualified Employer's appeals committee. In support of this application, the Claimant states as follows:

1. This request is filed with the Workers' Compensation Commission within one (1) year of the Claimant's receipt of the notice that the adverse benefit determination, or part thereof, was upheld by the Qualified Employer's appeals committee.
2. A true and copy of the adverse benefit determination being appealed to the Commission en banc is attached.
3. Following are the specific issues in the adverse benefit determination to be reviewed. General allegations of error do not suffice. *(Attach additional pages if needed.)* _____

**Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a):** "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

**Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.**

**I declare under PENALTY OF PERJURY that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete.**

Signed this _____ day of _____, _____.

| | |
|---|---|
| Signature of Claimant | Print or Type Name of Attorney for Claimant, if any OBA # |
| Claimant's Address (Number and Street) | Signature of Attorney for Claimant |
| City State Zip | Claimant's Attorney's Address (Number and Street) |
| Claimant's Telephone Number | City State Zip |
| | Claimant's Attorney's Telephone Number |

**I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:**

| |
|---|
| Employer /Attorney for Employer |
| Address (Number & Street) |
| City State Zip Code |

**Created 12-18-14**