MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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P.O. Box 175, Majuro, Marshall Islands MH 96960
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Form WCP - 501
(Schedule 11 of the Workers' Compensation Regulations)

NOTICE CONTESTING ACCEPTANCE OF CLAIM FOR COMPENSATION

To be filed by Employer or Insurance Carrier within 15 calendar days after receipt of Compensation Order approving the claim by the Administrator. The employer may contest the claim for compensation if it can show evidence, not previously provided, that it is not liable for the payment of compensation. This notice must be filed with the Administrator with documentation supporting the appeal for reconsideration.

1. Name of employer/EIN:	2. Name of worker/SS number:
3. Employer address & contact phone no.	4. Worker's address & contact phone no:
5. Worker's usual occupation or job role:	6. Date of first knowledge of injury/illness:

7. The undersigned hereby appeals to the Administrator to reconsider her decision to approve the claim for worker's compensation by the subject worker. THE EMPLOYER MUST STATE THE GROUNDS UPON WHICH THE ACCEPTANCE OF CLAIM TO CONPENSATION IS CONTESTED. I am submitting the following new and additional evidence as proof that the concerns raised about this claim are valid:

(use another sheet if necessary and attach to this form)

8. Name, signature & title of person representing insurer	9. Name, signature & title of employer representative
10. Date of this Notice	11. Mail/Hand-deliver this notice to: **The Administrator** RMI Workers' Compensation Administration P.O. Box 175, Majuro MH 96960 Marshall Islands (MISSA Office)