pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
UNEMPLOYMENT COMPENSATION BOARD OF REVIEW

PETITION FOR APPEAL (WEB)

If you want to appeal a notice of determination, complete Section I below and submit this form. To be timely, an appeal must be filed by the last date to appeal as indicated on the determination.

ALL SECTION I FIELDS ARE MANDATORY

SECTION I: TO BE COMPLETED BY PERSON FILING APPEAL

CLAIMANT'S NAME AND ADDRESS:

DATE OF DETERMINATION BEING APPEALED _____

CLAIMANT'S SOCIAL SECURITY NO. XXX - XX - ☐☐☐☐

CLAIMANT'S TELEPHONE NO. (_____) _____ - _____

EMPLOYER'S NAME AND ADDRESS WHERE THE CLAIMANT LAST WORKED:

EMPLOYER'S TELEPHONE NO. (_____) _____ - _____

REASON(S) FOR DISAGREEING WITH THE DETERMINATION AND FILING THIS APPEAL ARE:

I certify that all information I have provided in this document is correct and complete. I acknowledge that false statements in this document are punishable pursuant to 18 Pa.C.S. § 4904, relating to unsworn falsification to authorities.

_____

NAME OF PERSON FILING APPEAL

SECTION II: TO BE COMPLETED ONLY BY THE UC SERVICE CENTER

APPEAL FILED ON _____ REFEREE OFFICE _____ APPEAL NO. _____

APPEAL FILED BY: CLAIMANT ☐ EMPLOYER ☐

APPEAL RECEIVED BY: EMAIL ☐

TYPE CLAIM: UC ☐ UCFE ☐ UCX ☐ EB ☐ DUA ☐ TRA ☐ TRADE ACT PETITION NO. _____ OTHER _____ NAFTA PETITION NO. _____

APPELLANT REQUIRES ASSISTANCE BECAUSE OF DISABILITY WITH: HEARING ☐ SPEECH ☐ VISION ☐
FOR THE FOLLOWING SPOKEN LANGUAGE _____ OTHER _____

ELIGIBLE SECTION(S) _____ INELIGIBLE SECTION(S) _____

APPLICATION FOR BENEFITS DATE _____ CLAIM WEEK(S) RULED ON _____

_____ UC SERVICE CENTER _____

SIGNATURE OF APPEAL CLERK

NAME AND ADDRESS OF EMPLOYER(S) AND ANY OTHER PARTY INVOLVED IN THE CLAIMANT'S ELIGIBILITY

EMPLOYER'S ADDRESS **EMPLOYER'S REPRESENTATIVE (IF ANY)**

SAVE PRINT RESET SUBMIT