IN THE TULALIP TRIBAL COURT
TULALIP INIDAN RESERVATION
TULALIP, WASHINGTON

________________________________ Appellant, vs. ________________________________ Appellee.	**NO. TUL-CV-WC-_______________** **NOTICE OF WORKERS COMPENSATION APPEAL AND REQUEST FOR APPEAL HEARING**

(Appeal must be filed within 30 days of receiving notice of decision)

I am requesting the Court to schedule a court date to hear testimony to review the insurance decision. The Court has jurisdiction in this matter pursuant to T.T.C. Title 9, Chapters 9.15.

☐ Other, please specify:
____
____.

I. APPELLANT

Employee: ___________________________ Telephone: ___________________________
Address: ____________________________ Cellphone: ___________________________
____________________________________ Email: ______________________________
____

II. APPELLEE

Employer: ___________________________ Telephone: ___________________________
Address: ____________________________ Cellphone: ___________________________
____________________________________ Email: ______________________________
____

Tulalip Tribal Court
6332 31st AVE NE SUITE B
Tulalip, WA 98271
Tel. (360) Fax (360) 716-4773

III. FACTS

Date notified of insurance decision: ____

I feel that this decision was not justified because:

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Attach any relevant documents (i.e., notices, letters denying coverage, certified receipts, contracts/agreements, etc.)

IV. RELIEF REQUESTED

I am requesting the following relief should the Court determine that my denial was not justified:

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DATED this ______ day of ____________________, 20______.

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Appellant Signature

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