

NOTICE OF DISPUTE

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P O Box 30016, Lansing, MI 48909

1. Social Security No.	2. Date of Injury	3. Employee Name (Last, First, MI)		
4. Employee Address (Street No. and Name)		5. City	6. State	7. Zip Code
8. Employer Name				9. Federal ID No.
10. Employer Street Address		11. City	12. State	13. Zip Code
14. Carrier or Self-Insured Name			15. NAIC or Self-Insured No.	16. Zip Code
17. Service Company/TPA Name (if applicable)			18. Service Co./TPA ID No.	19. Zip Code
20. Claim or File No.		21. County of Injury		22. County Code (if known)
23. Reason For Dispute A. _____ Injury not work related B. _____ Medical treatment not related to injury C. _____ Further investigation required (please specify below) D. _____ Additional information required from employee (please specify below) E. _____ Vocational rehabilitation dispute only (please specify below) F. _____ Other (please specify below)				

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

Authority: Workers' Disability Compensation Act, R408.33(1)
 Completion: Mandatory
 Penalty: Workers' Disability Compensation Act, 418.631; 418.801; R408.33

This is to certify that a copy of this form has been mailed or given to the injured employee.

24. Preparer Name (Please print)	25. Signature	26. Telephone No.	27. Date
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NOTICE TO EMPLOYEE

By filing this form, your employer or its workers' compensation insurance company has indicated to the Bureau of Workers' Disability Compensation that it has a question or a dispute concerning the possible workers' compensation benefits to which you may be entitled. You may or may not agree with the position taken by the employer or insurance company.

If you feel that you are not receiving the benefits to which you are entitled, you should discuss this with your employer or a representative of its insurance company. If you have already done that or you are not satisfied with the discussion, you may request an informal conference or file a formal application for mediation or hearing. You can obtain the appropriate forms or more information by contacting the Bureau of Workers' Disability Compensation at one of the offices listed below.

DETROIT
State of Michigan Plaza Building
1200 Sixth Street, 12th Floor
(313) 256-2770

FLINT
Bristol West Center
G-1388 West Bristol Road
(810) 760-2618

KALAMAZOO
940 N. 10th Street
(616) 544-4440

PONTIAC
NBD Building
28 N. Saginaw, Suite 1310
(810) 334-2497

ESCANABA
State Office Building
305 Ludington
(906) 786-2081

GRAND RAPIDS
2942 Fuller Street N.E.
(616) 447-2670

LANSING AREA
2501 Woodlake Circle, Okemos
(517) 241-9393

SAGINAW
State Office Building
411-K East Genesee
(989) 758-1768

MOUNT CLEMENS
10th Floor, Old County Building
10 N. Main
(810) 463-6577

TDD in Lansing
(517) 322-5987

Form #

BWC-107

Form Name:

Notice of Dispute

When Required:

A carrier shall notify the bureau on or before the fourteenth day after the employer has notice or knowledge of the alleged injury or death, in all cases where the right of the injured or dependent to compensation is disputed.

Required Fields:

All applicable fields must be completed.

- ✓ Forms will be returned if fields 1-3, 8, and 14 are not completed.
- ✓ You will receive a letter if fields 4 and 23 are not completed.
- ✓ Do not use "Other" as reason for dispute unless absolutely necessary.

Instructions:

Completing the Form:

- ✓ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✓ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✓ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✓ Press Tab to accept the field change and go to the next field, or Press Shift + Tab to accept the field change and go to the previous field.
- ✓ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✓ To print, be sure to use the printer button on the Acrobat toolbar menu to print the form instead of your web browser's print function. You may need to select the "Print as image" option in the print dialog box to print the completed form.
- ✓ If you wish to print the form only, select "Print Current Page" or "Pages From: 1 To: 1"

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

If you have any comments on this fill-inform, please send them to bwdcinfo@cis.state.mi.us. Please include the keyword "Fill-In Form 107" with your comments.

How to Submit This Form:

- ✓ Print the completed form
- ✓ Sign and make 2 copies
 - ❖ Give a copy of the report to the employee
 - ❖ Keep a copy for your records
 - ❖ Mail the original signed Form 107 to:

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