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REQUEST FOR COMPLIANCE HEARING

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
PO Box 30016, Lansing, MI 48909

Type of hearing requested ☐ Rule 5 ☐ Rule 4(2) ☐ Insurance Compliance ☐ Other _____

Submitted on behalf of ☐ Employee ☐ Employer ☐ Insurance Company ☐ Other _____

Name of Employee (Last, First, MI)			Social Security Number	Plaintiff Attorney	
Employee Street Address			Date of Birth	Plaintiff Attorney Tele. No.	Attorney ID Number P-
City	State	ZIP Code	Employee Telephone Number	Plaintiff Attorney Email Address	

Name of Employer			Carrier or Self-Insured Name	Defendant Attorney	
Employer Street Address			NAIC or Self-Insured Number	Defendant Attorney Tele. No.	Attorney ID Number P-
City	State	ZIP Code	Service Company/TPA Name (if applicable)	Defendant Attorney Email Address	

A request for a hearing must contain sufficient information to warrant investigation or inquiry into an allegation of non-compliance. Please outline the facts and law involved in this matter. Include names, dates, amounts, and any other pertinent information. Also, specify the relief sought.

Name of Requester			Telephone Number*	
Street Address*			Email*	
City*	State*	ZIP Code*	Signature	Date

* If not listed in upper portion of form

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: MCL 418.205; 418.601, *et seq.*; R408.34; R408.35 Completion: Voluntary Penalty: None

WC-40 (1/12)

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