

UNEMPLOYMENT COMPENSATION APPEAL

You may appeal an adjudicator's determination on-line at www.fluidnow.com/appeals or complete and fax or mail this form to the fax number or address below. You may attach additional pages/documents. **Include the claimant's social security number on each page.** Any appeal must be filed within 20 calendar days after the mailing date shown on the determination. If the 20th day is a Saturday, Sunday, or legal holiday, the time for filing an appeal is extended to the next business day. The filing date will be the United States Postal Service (USPS) postmark date or the date the appeal is date-stamped received if faxed or sent via a delivery service other than USPS. If filing more than 20 days after the mailing date, explain why the appeal should be considered timely. **Claimants: Continue claiming weeks as scheduled while you are unemployed and any appeal is pending. If a decision is in your favor, only properly claimed weeks can be paid.** Call 1-866-778-7356 toll-free if you have questions about your claim or need instructions for claiming weeks.

Claimant's Name _____

***Claimant's Social Security Number:** _____

Mailing Date of the Determination Being Appealed: _____

Determination ID# (If shown on the determination): _____

Mark one: I am: the claimant; the claimant's representative; the employer; the employer's representative

Reason for Appeal: (You may attach additional pages.)

My name is: _____

My telephone number is: _____

Signature: _____

Date: _____

I need a translator for the hearing. Specify language: _____.

Provide the following information if different from or not shown on the determination being appealed.

Claimant's Mailing Address: _____

Telephone # _____

City, State, Zip Code: _____

Employer Account Number: _____

Telephone # _____

Employer Name _____

Mailing Address: _____

City, State, Zip Code: _____

Job site location: _____

If you are a representative filing on behalf of a claimant or employer, the following information is required:

Representative Name: _____

Telephone # _____

Mailing Address: _____

City, State, Zip Code: _____

Fax this completed form to the Office of Appeals at **(850) 921-3524** or mail to:

AWI Office of UC Appeals
Caldwell Building MSC 347
107 E Madison Street
Tallahassee FL 32399-4143

***PRIVACY ACT STATEMENT:** Provision of the claimant's social security number is mandatory pursuant to 42 U.S.C. 1320b-7(a) and will be used to enable the association of claim records with this appeal as authorized by Section 119.071(5)(a)2., F.S.

An equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. All voice telephone numbers on this document may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711.